The

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The Significance of Tuberculin Tests

By J. A. Myers, M.D., Ph.D.

The PUBLIC HEALTH NURSE

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EDITORIAL

Our members will note that the external appearance of the magazine has somewhat changed. We hope the new cover selected by the publications committee meets with approval. Not only do the "sumptuary laws" of dress alter in this mutable world, but everything else in our material existence—typography and book binding included—is subject to the inexorable law of change. Familiar as our old cover—adopted in 1921—grew to be, so we hope will become the new, which, as we look over our bound volumes, is really a return to the simpler form of the earlier years.

As to the interior, we hope during 1925 with the generous help of our friends to continue with some measure of success to interpret public health nursing not only to our members, but to others interested in its progress.

Concerning definite projects, we began in January a discussion of problems in connection with well-baby clinics, which one of our members remarked was somewhat analogous to taking the lid off a volcano. But we have courage to believe that a fair discussion of the points raised will be received open-mindedly, and perhaps will add materially by the end of the year to a clearer understanding of the perplexities revealed in the questions raised in the initial paper. That an open forum such as this is truly worth while has been shown by the valuable series of articles on Maternity Nursing as Part of a Public Health Program, taken up last year.

During the past year we believe we have published some material which has been helpful in the manifold perplexities of members of boards of directors, and it will be noted that this has been mainly contributed by board members themselves.

We hope to continue the series on nutrition problems, and begin one on questions of mental hygiene of special interest to public health nurses.

Our new department on problems and policies of public health nursing services is acquiring momentum, and though not yet in full spate, will, we hope, through the interest and furtherance of our members, fully justify its existence.

We—editorially speaking—have a special weakness for the romance of this

branch of our profession. Adventure and romance will always be words to conjure with and in few other callings open to women can more of both be found than falls to the lot of the public health nurse—so often the true pioneer—in mountain regions, on the great plains, the sea coasts and the lakes, the lonely places and wide stretches of this diversified lands of ours, and in the heart of our cities. We want more stories to continue those begun in "Our Adventurers."

We take the opportunity here of expressing fervently our gratitude for all who have so generously helped during the past year to make THE PUBLIC HEALTH NURSE a welcome m er, useful, and, we hope, not unornamental.

Plans for the grading of nursing schools, which are probably more diverse and individual in their standards than any other type of professional schools, were suggested ten years ago. The grading of other educational institutions has been proceeding rapidly and has produced, on the whole, excellent results. It is agreed by practically all experts in professional education that some plan of grading or classification on a national basis offers the greatest promise of general improvement in the case of nursing schools.

Proceeding on this theory, the National League of Nursing Education evolved a plan for the grading of nursing schools, which has been submitted to and endorsed by the American Nurses Association, the National Organization for Public Health Nursing, the American Hospital Association, the American College of Surgeons, and the American Red Cross. The American Medical Association has appointed a special committee to coöperate with the committee of the League.

The work, it is estimated, will take three years and will cost approximately $115,000. Expenses of the first year up to $15,000 were underwritten by our unfailing and generous friend Mrs. Chester C. Bolton, a member of the Board of Directors of the National Organization for Public Health Nursing, at the recent meeting of the Executive Boards of the three national nursing organizations. This gift means that the long cherished project is actually in sight. The nursing organizations have appropriated a substantial sum to help in making up the budget of the first year's work, and an appeal will be made to state and alumnæ associations and also to individual nurses, to help in raising the funds.

It may be well to explain, to avoid any misunderstanding, that no nursing school will be graded except at its own request and every effort will be made in every possible way to help schools.

The committee which sets the standards for grading will be composed of representatives of all organizations previously mentioned. Schools will be visited and grouped according to certain predetermined essentials of a good nursing school.

At the joint board meetings of the three national nursing organizations, it was brought out by a member of the National Organization for Public Health nursing that the grading of nursing schools was not a project for the National League of Nursing Education alone, since it was one which affected all nurses. As a professional group, nurses have certain privileges, duties and obligations. To express this fact, at the last meeting of the joint boards the following motion was made by Miss Fox:

> That the Joint Boards urge the American Nurses Association to start the undertaking of raising from the nurses of the country, with the full coöperation and full use of the machinery of the other two associations, a sum of money which is commensurate with the interest of the nurses in this enormous piece of work.

PROBLEMS IN CONNECTION WITH THE ADMINISTRATION OF WELL BABY CLINICS

By Borden S. Veeder, M.D.
St. Louis, Missouri

Editor's Note: This is the first of the papers we hope to print discussing the questions raised in the article by Mary V. Pagand, published in the January number.

I HAVE been asked to discuss the problems brought up by Miss Pagaud from the standpoint of the pediatrician. My interest, however, is a much broader one and I prefer to discuss it from the general viewpoint of Child Welfare. The "well baby" clinic has evolved from the clinics for sick infants and milk stations, and is a very recent step as it is still in its "teens." The misconception of regarding it as a distinct entity rather than but *one method* in a broad educational program has been quite general. Education in the better care of children's health has been brought about through many factors—better pediatrics, home visiting by nurses, better milk and food propaganda by means of the press, welfare stations, etc., and the value and part played by any one method has not been determined. Suppose we had no well baby clinics but all the other methods of education—would our results be any worse or better? My own feeling is that it has certain fundamental weaknesses of method, which I will refer to more especially later, which lead me to regard the well baby clinic as a temporary expedient or educational method. My viewpoint may change in a few years. It is far from an ideal method and cannot compare with proper preventive pediatrics in private practice. This I state from experience and not from theory.

1. *What income limit, if any, should be adopted for patients attending a well baby clinic?* The first question raised is that of a clinic restricted by income or one open to everyone. So far as the physician is concerned I do not believe this question is very important. Individuals who can pay and who are worth having as patients will not accept charity unless it is absolutely necessary. It is much more important from other standpoints. The cost of an unrestricted free service is way beyond what the method justifies asking private charity or taxation to support. The great weakness of our St. Louis centers lies in trying to look after too many infants. The greater the number of conferences held the more the nurse must be in from her field work—regardless of the number of nurses the field nurse should be in attendance at the conference.

A solution by indefinitely multiplying centers would put too much of a burden on private charity, and on taxation, which has jumped billions in recent years and is already a menace as many economists point out. If then there is an economic limit and at the same time a quantitative limit on the actual conference work the attendance must be limited. If it is to be limited the most practical limit seems to me to be a financial one. We must ask those who know their child should have supervision—attendance at the conference shows this—and who are financially able, to pay for it as they pay for everything else. One might also mention the world-old observation that if people really want a thing and it is worth having they will find the means of getting it.

I do not believe that a "trained pediatrician" is an essential. Pediatrics is being taught in our colleges quite differently than it was a few years ago and a group of general practitioners quite capable of guiding the health of a child is being turned out of our medical schools. It is my belief that the problem of better health and care of children is essentially one of medical education rather than one of lay propaganda, welfare conferences, and public health measures. These are only accessory methods and means.

2. *How shall the financial status of patients be determined?* The question of what limit and how it should be determined in individual cases is a difficult one. The figure must vary in different localities and from time to time in the same locality. Detailed investigation in each case is out of the question and in the long run the mother's statement as to income has as little percentage of error as investigation. A competent nurse on a home visit should be able to size up the situation. It has been my observation that when there is a wide open clientele at the clinic the better educated and financially well off receive more attention from the nursing staff than the ignorant and poor who are less cooperative, to the detriment of the latter group who are not so coöperative but who need help the most. This is only human, but it is a distinct pitfall.

3. *When shall prescriptions be given in a well baby clinic?* This must be answered from a practical standpoint. The line of *no* prescription must be emphatic. Otherwise there is no line and the well baby clinic becomes a treatment clinic rather than an educational one. Not only is this impractical from an executive standpoint but it emphasizes one of the fundamental defects of well baby conferences—the gathering together of a large number of babies in a common meeting room. At nearly every conference a mother brings in a sick, coughing baby or one with an early pertussis or some other infection. Today—speaking as a pediatrician—we realize that infection is a more common cause of malnutrition in infancy than improper feeding—so much progress having been made in proper feeding in the past few years.

4. *Shall physicians in charge of well baby clinics accept clinic patients as private patients when illness occurs?* This brings up another fundamental weakness of well baby conferences. To have one physician look after the growth and development of the baby and cognizant of its developmental peculiarities and then to expect another physician to step in when it is sick and take care of it without this knowledge is most illogical and *directly contrary to the ideal preventive pediatrics.* This is the point that makes me feel that sooner or later as the public becomes educated to the need of preventive pediatrics, and the medical profession, as it is slowly but steadily doing, changes its mental attitude from care of the sick to maintenance of health and is prepared to assume the work—the well baby conference will pass into history. I do not wish to be misunderstood—it is at present a necessary step or stage in our program of education, but I do not think it is a permanent one and hence we should be careful and not overbuild our structure. At the present time although there is every logical reason why the clinic physician should look after the "conference baby" when it is sick, from the standpoint of expediency—compromise, if you wish to call it such—it is best to follow the attitude of the New Orleans Association. Our real task is to get the private physician to take an interest in the well baby work and the more we work with him the quicker the ultimate goals of child hygiene will be reached even if at present in individual cases it works a hardship. Child Hygiene work is essentially an educational problem and education is slow and laborious work. Have patience.

A LITTLE ABOUT FINLAND

By Kylliki Pohjala, R.N.

Editor's Note: Miss Pohjala is a graduate of the University Hospital of Helsinki, Suomi. Before studying nursing she had studied theology and had later been the assistant editor of a Finnish newspaper.

After completing her training, Miss Pohjala served as a nurse in the "White Army" in Finland and Estonia during their war of independence.

During the past four years she has been traveling and studying in Europe and the United States, acquainting herself with nursing conditions. Recently, at the request of Finnish Settlements in this country, Miss Pohjala toured the East and Middle West, lecturing on conditions in Finland.

SUOMI, Finland, is situated, as you know, between Sweden and Russia, reaching up to the Ice-Sea in the North. It is quite a large country, eight times the size of Denmark and twice the size of Kansas State. But there are only a little over three million people. The Finnish name of Finland is *Suomi*, which means marshland. The Finnish language is an extremely difficult language. No foreigner is able to learn it unless he makes it his life study.

Finns belong to what is known as the Fenno-Ugric race, which during the great exodus of the races populated the southwest part of Finland, pushing the Lapps to the extreme North. There they lived for over two thousand years a happy life, the life of a big child, hunting, fishing and singing. The ancient folk-songs are gathered into our national epic, called "Kalevala," which is regarded as one of the most precious contributions to the world's literature. How strange it must seem to America to know that Longfellow imitated the Suomi epic "Kalevala" in his beautiful poem "Hiawatha."

But in the year 1159 a strange power came to disturb the peace of Finland. The Swedish King, the Holy Eric, brought Christianity and raised the Swedish Flag. This contact with Sweden also spread the Western culture to Finland. As early as 1640 our first University was established. The various museums and the ruins of the old fortification hold many valuable evidences of our early civilization. But with the Swedish civilization came heavy taxes, and Finnish bravery was needed in Swedish wars. Finland was a continuous battlefield for about eight long centuries. Its national song describes this endless battle:

> Who tells, of all the fights, the tale
> In which this folk withstood;
> When war did rage from dale to dale,
> When frost set in with hunger's wail
> Who measured all their pouring blood
> And all their patience good?

After the war of 1808 Sweden was compelled to accede the whole of Finland to Russia. Now she was put amidst strange people, people who had an entirely different religion and culture. The Finns received this change with great anxiety. The Tsar Alexander I, who personally opened the first Finnish Parliament, declared that henceforth Finland would form an independent part of Russia, promising to respect its religion and laws. Indeed, in his younger days he was a man of high ideals, but the times kept changing and the best men of the nation, who dared to stand for the given rights, found themselves in boundless Siberia and its prisons.

The ancient Finnish musical instrument described in "Kalevala"

But never anything so bad that some good cannot result. The thought to overthrow the yoke of oppression sprang up spontaneously among the people. They were not children any more, but a nation, conscious of rights, and when the revolution started in Russia, our hopes for independence were realized. In 1917 Finland declared herself a Republic. This was a

brave act and had to be paid for with blood.

Finland is called the land of the midnight sun and the land of a thousand lakes, and it certainly may be called so, as there are 45,000 lakes. Some of

Finnish peasant women in kerchiefs which they always wear

these lakes are extremely beautiful with their many islands and inlets surrounded by magnificent trees.

In what is the charm and beauty of the North? More than anything in variety of coloring from bright amber to orange and russet, from the pale bluish green to darker shades of green, and in the spell of a creeping afternoon under a delicate blue sky so soft that one's eye can hardly see it in its peculiar charm; it must be felt.

What about the characteristics of the mysterious Finns? On the one hand they are slow, pious, of barbaric simplicity and resignation; on the other hand they are poetic, very musical, keenly progressive and most responsive to ideas. They have the name of being very honest and truthful to a fault. They have vigorous moral standards, take an active interest in public affairs and show a keen sense of independence. They are sensitive about their individual freedom, and sometimes extremely moody. As a whole the Finnish race is very intelligent. Old proverbs tell of an ancient wisdom, old legends, ballads and fairy tales of a poetic imagination, and today you will find practically no illiteracy among the Finns. Finland believes in its future, a free nation among the other nations.

Helsinki (Helsingfors), the capital of Finland, has the honor to be the meeting place of the International Conference for Nurses in 1925. Aho, a great Finnish writer, wrote once: "Our capital is certainly coquettish, and we have reason to be proud when strangers

The Finns love outdoor life from early youth

express their satisfaction and eulogize us. We are fond of saying that our streets give an impression of central Europe." Helsinki is situated on a cape of land projecting into the open sea. To the east and west, an archipelago of little islands spreads itself in infinite variety. Helsinki is a beautiful city and now very proud to receive as guests, nurses from foreign lands who will come to the meeting of the International Council of Nurses, July 20 to 25, 1925.

The American Nurses Association has appointed as delegates to the Congress of the International Council of Nurses:

Adda Eldredge, R.N.
Clara D. Noyes, R.N.
Laura R. Logan, R.N.
Elizabeth G. Fox
Mrs. L. E. Gretter, R.N.

The first post-graduate course for Finnish nurses was arranged in September, 1924. The length of the course was six months. There were seventeen students, five of whom had scholarships.

THE SIGNIFICANCE OF TUBERCULIN TESTS IN THE DETECTION OF TUBERCULOUS INFECTION*

By J. A. Myers, Ph.D., M.D.

Chief of Medical Staff, Lymanhurst School for Tuberculosis; Assistant Professor of Preventive Medicine, University of Minnesota

Nurses are sometimes called upon to interpret tuberculin tests in schools and are frequently asked many questions regarding such tests. It is these facts which brought the request for the present discussion.

YOU recall how the stage had been set for the discovery of the tubercle bacillus announced in 1882—how a worker by the name of Klenke for the first time, to our knowledge, in all the world's history had successfully experimented with tuberculosis in 1843. He took some of the sputum from tuberculous patients and injected it into the bodies of rabbits and found that every one of these animals became tuberculous. It happened that he lived far in advance of his time, and it was impossible to convince people that tuberculosis was communicated through the sputum or pus cast from the bodies of tuberculous people and animals. Nothing further was done and few or none could be convinced of the value of these experiments. In 1867 a French scientist, Villemin, went a step further by using other animals in addition to the rabbit. He also produced tuberculous processes by injecting sputum and pus from tuberculous patients and animals into bodies of these experimental animals. About eleven years later, Conheim confirmed the work of Klenke and Villemin, but he also went a step further. He knew that his predecessors had not been able to convince the world of the truths they had discovered. So he injected small quantities of material taken from tuberculous patients into the anterior chamber of the eye of the rabbit, and there through the clear cornea he was able to watch the tubercles develop from day to day. Moreover, he could bring in his friends and colleagues, and could actually show them how the tubercles developed. Thus he was able to convince them that tuberculosis was transmitted through the sputum which the tuberculous patient expectorated.

During this same time a great deal of work had been done along other scientific lines. The microscope had been perfected, Pasteur had lived, and along with other notable accomplishments the chemists had made productive studies of the dyes. About this time there appeared a man for whom the stage had been set—Dr. Koch, practicing medicine in a small country town in Germany.

Discovery of the Bacillus

Koch was familiar with the scientific experiments on tuberculosis of his predecessors. He had followed the work carried on by the chemists. He became interested in the study of the tubercle bacillus under the microscope. In this way he studied sputum that had been expectorated by tuberculous patients. He noticed that in this sputum there was always present one type of germ. It was a rod-shaped, very small germ. Then he made use of the dyes, and finally he was able to use combinations which when properly employed would always stain this one germ and leave the others unstained. He then thought it would be interesting if he could grow these germs in pure cultures, so he began to investigate the food of germs. He found that he was able to devise a food upon which just this one kind of germ would grow and all the others would die.

Now he had reached the stage where he felt that he was about able to announce to the world that he had discovered the real cause of tuberculosis, but before doing this he wanted to do one

* Read before the school nurses, Department of Hygiene, Board of Education of Minneapolis, October, 1924.

final thing, and that was to take these germs from the pure cultures and inoculate them into the bodies of animals. He inoculated them into many animals, consisting of rabbits, guinea pigs, etc. Every animal so inoculated developed tuberculosis and from their bodies he could recover the germs of tuberculosis. He was then able to announce to the world in 1882 that he had discovered the real cause of this disease. He named this germ the tubercle bacillus.

Tuberculin Developed

Now the fact having been definitely established, that this is the organism that always causes tuberculosis, and that this disease never develops in the absence of the tubercle bacillus, Dr. Koch was able to make further study. In the following eight years he developed a new preparation known as tuberculin. It is merely the production of the activities of these germs plus, in some cases, the dead bodies of the germs themselves. This was impossible before Dr. Koch was able to isolate the germs and grow them in pure cultures. He thought he could inject tuberculin into the bodies of people and finally establish an immunity to tuberculosis. He did this with a large number of animals. He then made an error which is often said to be the only mistake he ever made—he announced to the world that he had discovered a cure for tuberculosis. He believed that tuberculin would establish an immunity and he even predicted that there would be a time when there would be no tuberculosis.

Now it happened that while all of this was going on the veterinarians were studying tuberculosis in animals. They had found that tuberculin was extremely valuable to them in detecting tuberculosis in animals. They had found that by injecting the tuberculin into the animals they would often get reactions when there was no other evidence of the disease and the germs themselves could not be found in the excreta of the animals. They slaughtered these animals and found in nearly every instance that they had tuberculosis. This then became an extremely important test to veterinarians.

Knowing how valuable the tuberculin test had become to the veterinary profession, clinicians treating tuberculous patients decided to use it in detecting tuberculosis in people. They found that they were able to obtain reactions from people such as the veterinarians had obtained from animals. Since that time tuberculin has found its most important place in the detection of tuberculosis. Today, it is our most valuable aid in detecting tuberculosis infection.

The Von Pirquet Test

While this work was going on, a physician in Vienna became interested in the scientific study of tuberculosis. Dr. Von Pirquet believed that every one who had ever been infected with tuberculosis would give a reaction if this test were applied. By 1907, Dr. Von Pirquet had concluded his experiments and had proved that the positive reaction meant tuberculous infection.

Most school nurses are interested in the technique of applying the von Pirquet test. In the first place, an area of the surface of the skin—(it does not make any difference what part of the body, although usually the fore-arm is used)—is cleaned with sterile cotton that has been dipped in alcohol or ether. Then this area is thoroughly dried with sterile cotton. A needle which has been sterilized is used in making three scarifications on the skin. These are placed several centimeters apart, that is, one or two inches. In making these, great care must be taken that they are not cut too deeply, that is that the blood vessels are not punctured so there is no bleeding whatsoever. It is only the outermost portion of the skin that is removed.

Now that these three scarifications are ready we take a solution of tuberculin that has been prepared by diluting raw tuberculin with four parts of sterile glycerine. One drop of tuberculin is placed on the first, and another drop is placed on the third scarification.

We place nothing at all on the second scarification. That leaves us two tests, the scarification nearest the body and the one farthest from the body. The middle one serves as a control. These are left exposed to the open air for a few minutes. After that a light cotton dressing is applied, merely to prevent the tuberculin from becoming removed. The dressing is usually left on for two or three hours.

The scarifications are examined at the end of twenty-four hours and again at the end of forty-eight hours. Now if the test is negative at the end of twenty-four hours and again at the end of forty-eight hours, all three of these areas will look precisely the same. There is no redness present more than would be produced by a slight scratch of a needle. There is no hardness about any of the scarifications. If, however, the test is positive, by the end of twenty-four hours, one sees around the scarifications where the tuberculin was applied a definite redness. Sometimes there is even a purple hue in the center of the area. There is also a hardness of the skin about these areas. This applies to the two that have had tuberculin applied. The center one is entirely without redness or hardness. One of the most characteristic things is the fact that one is able to pick up between the fingers the skin around areas where the reaction is occurring and feel a definite hardness of the skin. There is a sense of elasticity, whereas the central or control area shows none of these characteristics.

The size of this red area varies a great deal in different people usually from one-sixth of an inch to one inch in diameter. In some cases, there may possibly be a larger reaction. The point that is extremely important is the redness that appears, the hardness of the skin of the areas, and the size of these areas, varying from one-sixth to one inch in diameter.

The tuberculin test as applied by von Pirquet is not infallible. We know that there are certain conditions which may exist in the body which give a negative test when in reality the person has a tuberculous infection. This is true, for example, in acute infectious diseases, such as measles and diphtheria, particularly when they occur in severe forms. We find cases who are known to have positive von Pirquets but who show negative reaction during the time they are suffering from such acute diseases. However, after the acute infection has disappeared the von Pirquet becomes positive again. Therefore one should not rely on this test if it is applied when the child is suffering from one of the acute infectious diseases. Again it is known that in cases of advanced tuberculosis the von Pirquet test may be negative.

The von Pirquet is a safe test. Occasionally, however, one finds a person who will not be convinced of this fact. One mother, for example, called a pediatrician to see her infant who had signs of spinal meningitis. In determining the type of meningitis a consultant was called. It was agreed that a von Pirquet test should be applied. This and other evidence led to a diagnosis of tuberculous meningitis from which the infant later died. To this day that mother insists that the von Pirquet test was responsible for the death of her infant. There are, however, a few conditions in which the von Pirquet test is not indicated. One of these conditions is tuberculosis of the skin. It is better not to apply the von Pirquet or any other tuberculin test to anyone while a patient is suffering from a disease that causes skin eruptions.

Nurses Can Help Prevent Misunderstanding

The question arises as to just what a positive von Pirquet tuberculin test means. As to this there is apparently a great deal of misunderstanding among the public, and certainly it is the nurse who must help instruct the public. A positive test means that at some time that individual has been infected with tuberculosis. It does not tell us a single thing about when the infection occurred. It does not tell us a single thing about where the infection is, or how extensive it is. Moreover, it does

not tell us whether the tuberculous process is in an active or inactive state. The only thing a positive tuberculin test tells us is that at some time that individual has been infected with tuberculosis.

Often persons who have had no opportunity to gain knowledge concerning diseases will read statements to the effect that 90 per cent of all children have been infected with tuberculosis by the time they reach the age of fifteen years. These figures that are so frequently seen in textbooks are true of certain large cities, particularly of European cities, where the people have lived in crowded quarters a long, long time. If we go into the rural communities, we find the percentage of children with tuberculous infection lower. In fact, Slater found among 1,500 children in the rural districts of Southwestern Minnesota that only about 10 per cent had been infected. In making a study of the inhabitants of Saskatchewan, Ferguson found that 56.6 per cent of 1,346 children between the ages of six and fourteen years were infected. One must not think that all children with tuberculous infection have or ever will have tuberculous disease. Indeed only a small percentage of those infected ever develop the disease. This is because they have sufficient resistance to hold the tubercle bacilli in check throughout life. A few however with low resistance are unable to keep the germs walled off. In their bodies the germs proliferate, then produce poisons which result in symptoms of the disease.

The Manteaux Test

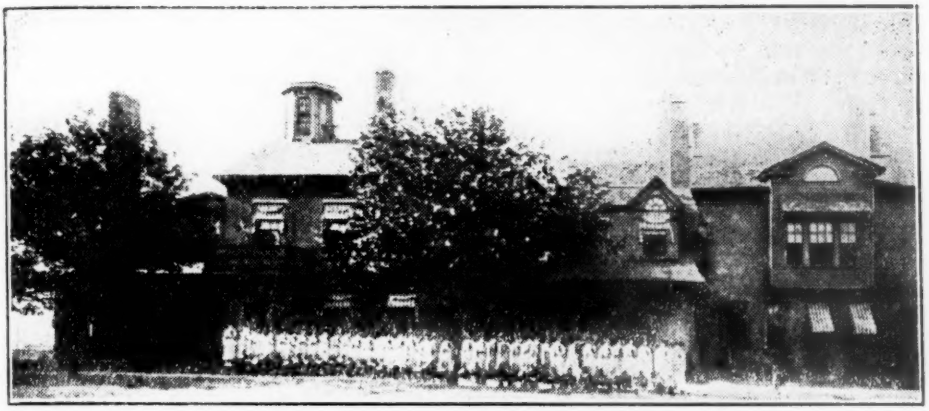
Another tuberculin test has become very popular, and is believed to be slightly more accurate than the von Pirquet test. It is the Manteaux test. It is used quite extensively in various parts of Europe and is now being used considerably in this country.

Manteaux places in a tuberculin syringe a solution of one part of tuberculin to 5,000 parts of normal saline. With the skin prepared as for the von Pirquet test he catches up the skin between the thumb and index finger of the left hand. With the other hand he holds the syringe with the needle almost parallel to the surface of the skin. He then inserts the needle between the layers of the skin. When it is in the proper position, he injects a single drop of the tuberculin solution.

In twenty-four hours and again in forty-eight hours, we find that if the test is negative there is absolutely no reaction; there is nothing to be seen except a slight redness along the course which the needle took. If the test is positive, however, we find at the end of twenty-four hours and again at the end of forty-eight hours there is a definite deep red nodule which varies in size from one-half to one inch in diameter, and that surrounding this hard red nodule there is usually a good-sized halo of pinkness.

A positive Manteaux test, although it looks slightly different, has precisely the same meaning as the von Pirquet test. In some cases one gets a delayed reaction in both the von Pirquet and the Manteaux tests. That is, the characteristics that should appear by the end of twenty-four or forty-eight hours do not appear for three or four days. No test, therefore, should be reported as negative until three or four days have elapsed.

THE VISITING NURSE ASSOCIATION OF CLEVELAND, OHIO*



Perry House

IN the year 1901, The Cleveland Visiting Nurse Association came into existence. The need for it was first sensed by the Graduate Nurses Association, whose members realized more forcibly each day that free nursing service was essential for the general good of the community. Seven hundred and seventy-four dollars and sixty cents was raised through a distribution of circulars asking for financial assistance and coöperation from the public.

The Baker's Dozen, a charitable organization composed of young Cleveland women, came to their assistance by giving a subscription "german" which netted $1,200.00, sufficient for the first year's expenses. This same group, headed by Mrs. P. W. Harvey, started the work with a staff of four nurses.

Miss Alice W. Page, the first nurse in charge, came well prepared, having been connected with the Association in Chicago, and having also helped to organize the district work in Columbus, Ohio.

The first efforts were concentrated in three congested districts, in which, through the generosity of private citizens, the Association was given office space in the settlement houses. Calls in other parts of the city were accepted and investigated. By the end of 1907, three new centers had been opened, which always meant that some individual or some group of people in that district helped meet the expenses.

When three years old the Association was incorporated. This same year, with the aid of Western Reserve Medical College, the first tuberculosis dispensary was started with a special nurse. As nurses were added the Visiting Nurse Association paid their salaries and supervised them until they were taken over by the Anti-Tuberculosis League and later by the city.

In coöperation with another group of agencies the Association gave nurses, money, time and enthusiasm to start the Babies' Dispensary and Hospital and the City Prophylactic Dispensaries.

In 1909, another epochal year, we furnished and supervised two nurses for school work and two nurses to investigate contagious diseases. These were the first nurses salaried by the city. Through our efforts nurses were also placed in several industrial concerns. This was the nucleus of the present industrial nursing system in Cleveland.

THE PUBLIC HEALTH NURSE of today was started as a quarterly by The Cleveland Association in 1909 and

* The eighth of the series depicting the homes and activities of voluntary, municipal, and state public health nursing organizations.

offered to the National Organization for Public Health Nursing at their organization meeting in June 1912, with the seal, designed by a Cleveland artist, Herman Matzen, made possible by the gift of $500.00 from Mrs. E. S. Burke, Jr. The seal has been copyrighted, but its use is granted to all Public Health Nursing Associations.

The present university teaching center of Cleveland was started in 1911 by the Visiting Nurse Association with the coöperation of the Anti-Tuberculosis League, Western Reserve University, Associated Charities and Babies' Dispensary and Hospital, which was continued under the same group until 1916 when it was taken over by the School of Applied Science of Western Reserve University, although, with the exception of the Director's salary, it was still wholly financed by the Anti-Tuberculosis League and the Visiting Nurse Association until the Federation assumed that responsibility in January, 1921.

During the early years of growth the aim was to care only for those unable to pay, even to the extent of ruling that, with a few exceptions, if a patient could pay more than twenty-five cents for a visit care was refused.

Our fifteenth birthday was celebrated by very quietly inaugurating a so-called "Pay Service," available to all, which was made a part of the general service. The earnings, however, were recorded separately—totalling the first year $1,731.43.

At present 9½ per cent of our income is from patients; 27½ per cent from contracts; 14 per cent from endowments; 47½ per cent from the Welfare Federation and 1½ per cent from other sources.

In 1919 the Visiting Nurse Association, with several other nursing groups, was invited to move the main office to the Cleveland nursing center, the wonderful old home of Commodore Perry —now called Perry House, which has been written up in THE PUBLIC HEALTH NURSE for November, 1920.

The achievements, possibilities and needs of modern hygiene are to be demonstrated at an Exposition of Hygiene and Sanitation to be held in Vienna, Austria, during April and May. Americans visiting Europe this spring might well add this exposition to their list.

A CASE STUDY METHOD OF TEACHING NURSING

By Effie J. Taylor

Associate Professor, Yale University School of Nursing

Heretofore in discussing the case method of study we have perhaps thought in terms of a "typhoid case"—a "pneumonia case." In so thinking we have tended to separate the illness from the individual who is ill, and considered the nursing only in terms of immediate hospital nursing needs. We think now in terms of the "total nursing responsibility to a human being, as a part of a family and of a community, ill now with, let us say, pneumonia."

To those of us who believe that the time will come and should come when *all* nurses are truly public health nurses, this description of the case method of teaching nursing as being tried out at the Yale School, is very suggestive.

MARY E. RICHMOND in the preface to her book on Social Diagnoses, after struggling to find methods of work which were solely adapted to the treatment of families connected with a charity organization, says:

> It soon became apparent, however, that no methods or aims were peculiarly and solely adapted to the treatment of families who found their way to a charity organization society; that in essentials the methods and aims of social case work were or should be the same in every type of service.

A similar observation was made by Mr. Dawson, Secretary of the Organized Charities in New Haven, who is directing a course in the Yale School of Nursing on methods of case work. When he had read and discussed the outlines upon which our student nurses were directed to build up their case studies and histories, Mr. Dawson said that the striking thing to him was that our method of approach could be applied to any field, medical, social, as well as nursing. Knowing well that nurses are called upon to serve in any and every field of health activity we aimed to give the students a method of work which could be used in all their contacts with human beings, and to teach them how to make a scientific approach to information which would enable them to understand the mental, social and physical life of the person they were endeavoring to serve either as a separate unit or as a member of a group in a social structure.

In establishing the Yale School of Nursing there were three distinct provisions:

1. An improved plan of education.
2. The shortest possible period of training.
3. Emphasis throughout the course on public health.

The plan upon which the course of study is based is "The Case Study Plan" and this paper is concerned with the case study method as used in the Yale School of Nursing.

The first lesson in practical nursing outlines a plan on which the student may build her observations and is devoted to a consideration of the hospital with emphasis placed upon it as a home for the patient to live in. The hospital is discussed in its relation to other institutions and to its function and responsibility in the community. It is also discussed in its relation to the university and its function as an educational institution and teaching center. Assignments for reading dealing with the hospital and its community relationship are selected. The students are guided on an excursion through the hospital and the plant is thoroughly explained. Emphasis is placed on the ward arrangements and the desirable and undesirable points relating particularly to the comfort and welfare of the patient are discussed. The first exercise required is a written description of the hospital organization and plant.

Community Point of View Established at Outset

Other class periods are spent in discussing the relationships which exist between the various personnel in the hospital and between the personnel of the hospital and the workers in outside agencies with whom the student is likely to come, more or less, in contact.

Coming, as these discussions do, at the beginning of the course, the community point of view is established at the outset and the students feel a keen interest in the workers who come into the hospital or dispensary, and recognize them as a part of the program in which they soon begin to feel they have an important place.

It is planned that the student will keep a record of her experience and forms have been worked out on which she tabulates the facts of the cases, the observations she makes on the individual patient's condition, and on her own progress. A summary of this case experience is made by the student at the end of each month and is filed as a record of work completed. This summary provides the supervisor with a means of accurately checking the students' opportunities and providing for possible deficiencies or necessary repetitions.

The students from the outset are encouraged to read records and to ask questions and to look upon the head nurse as the person to whom they may go for information and help not only relating to their ward practice but to the condition of the patients as well. Consequently a close relationship has been built up and the responsibility for teaching is frankly accepted by the head nurse. Before beginning lectures on the various diseases the students are directed to read and seek information about the various conditions they find in the patients with whom they come in contact. If the patient has been admitted through the dispensary or one of the social agencies they are encouraged to read the records and keep in touch with the advice given or plans made for the patient's return to the community. Encouragement is given the student to bring cases to conference. If anything particularly interesting is discovered it is brought to the attention of the whole group and discussion as to ways and means to meet the various problems which arise is encouraged.

A similar method of procedure is carried out in teaching other courses and applications are made to specific situations wherever possible. Problems in psychology, anatomy and physiology and physiological chemistry which can be explained by cases in the wards are dealt with in this manner. The student is directly related to the patient and the case discussed and analyzed. Sometimes a home situation is involved and while in only a limited number of cases can the student be directly related to the home she is given a picture of the environmental factors which enter into and affect the condition. It has been possible, however, to allow every student in the early weeks of her course to make at least one home visit in a selected area with the visiting nurse and it has been interesting to note the influence of such a visit on the student.

Students' Interest Aroused

The students are eager for the information and do not find the special assignments irksome. Each new contact brings a new thrill and interest which no routine procedure ever approached. As the students pass on from the pre-clinic period to become first year students and are assigned to the study of specific cases for whom they are to give the entire nursing care it is delightful to hear them talk about their cases as though they were personal friends. They know about the mother, the father, the husband or wife or the baby at home.

No longer to a student do her patients mean the first four on the right hand side of the ward. One is Mrs. B. who lives at 200 G Street and has five children all under ten years of age. She is going to be discharged tomorrow but must still remain in bed at home for several days. In order that she may carry out the instructions given her the visiting nurse has been notified and will visit each day and the visiting housekeeper will also help in adjusting things so that the mother may rest. The student knows these arrangements and sees the patient discharged with confidence that she will be well cared for.

According to the curriculum the students are assigned to patients in the medical and surgical wards for the first four months following the pre-clinic period of four months. Concurrently with this assignment they begin their lectures and classes in medical and surgical diseases and in medical and surgical nursing.

When a student is assigned to a particular ward the head nurse in conference with the supervisor assigns the cases and when the student has received the necessary information to make it possible to begin the care of a patient she undertakes the responsibility for the care of that patient in so far as her experience at that time will permit. She has access to all the information available concerning the patient and is instructed in the interpretation of laboratory records and findings. If the case is a special one, as for example a metabolism case, she may assist in some of the laboratory examinations. Every case is recorded daily in the student's experience record so that at the end of any period she is able to tell what cases she has seen, what were the diagnoses, what treatments were administered, what repetitions of procedures were made, and such other information as the headings on the record provide for. It has taken a good deal of time and much careful instruction and supervision to direct the student to an interpretation of the headings and to a differentiation of observations made.

During the pre-clinic period and previous to the time when the medical and surgical courses are given the student in writing her case histories uses only the first three headings which include

I. History
II. Symptoms
III. Diagnoses

with their subheadings. After the lectures have been given questions of "treatment," "results," "prognosis" and "follow up" are included in the data discussed and recorded. The assignments to cases are made once each week, varying in number according to the type of patient and the number of hours the student is on duty in the ward.

One case study each week, with a maximum of six in each service, is required and these are discussed with the head nurse and corrected as to accuracy of statements. They are then referred to the supervisor who holds a conference with the student in which is discussed the method of handling and recording the facts discovered. Comparisons are made with the various cases studied by the different students in order that the group may have the advantage of all the available experience on the wards. In addition to experience records and case studies kept by the students, a record of nursing procedures practised is kept by the supervisor in each department.

Value of Record Keeping

A question may arise as to the value of spending so much time in record keeping. As a matter of fact when the records are kept each day the time consumed is much less than one would think. For the experience records the students do not average more than fifteen to twenty minutes a day. Somewhat less time each day is given on an average to the writing of a case history and the interest to the student quite compensates for the time spent.

The most important advantage gained by the student in compiling the information is a method of work. In discussing the matter with one of our faculty who is doing research work in another department she was asked, "What do you think was the greatest gain to yourself from the recent piece of research you have just made?" Her reply was, "The greatest asset to myself was a method of work." We believe that is the greatest asset to our students. They are given a scientific approach to obtaining information. They are taught how to use a plan. They are taught accuracy of statement, observation and an appreciation of statistics and in gaining information through the actual care of the patients

they are building up an attitude of mind towards the value of achieving education through service and experience. In addition through recording actual happenings and material, lasting impressions are made, and through the filed records each student is building up a bibliography compiled by herself, criticized and corrected for future reference.

The student is interested in keeping these records and in making a summary of her case experience for permanent filing because she understands that she is making a personal contribution for future work. She is sharing in a piece of scientific research from which in the future scientific data will be available. Such topics as these are discussed in conference with the student and the value placed upon accurate record keeping affords an impetus to them to put forth their greatest effort.

Through a record of cases observed material is quickly becoming available as to what is actually the experience in the various wards. These records also enumerate repetitions of experience. They show exactly how the student's time is spent. To summarize, they record a statistical survey of what is available in the field and how this material is used by the students.

It is much too soon to speak in terms of a permanent record form or whether or not the methods used in compiling the data are adequate. It seemed important that a type of record be adopted as a temporary work sheet from which to make, if desirable, additions or variations.

Much thought is being given to perfecting the system in order not only to provide a set of records for filing but to provide facilities through which the student may acquire a sound method of work and a scientific approach to gaining and recording accurate information.

With a view to studying the causes of endemic goiter in the Valtellina (Piedmont, Italy) and in order to interest the government in its initiative, the Antigoiter Committee of the Valtellina province has for two years been applying the iodine treatment to the school children of the region, with undeniable results.

During the past year 9,350 school children (three-fifths of those of elementary school age) had their necks measured and were classified according to the state of their thyroids, as follows:

a. Imperceptible
b. Slightly noticeable
c. Diffused
d. Globelike
e. Knotty
f. Cystic.

All were treated equally with chocolate drops containing iodide of potassium, the best results being obtained with two weekly doses of 7 centigr. This gave a total expense of lire 13,578, or lire 1.42 a head.

Next year the Antigoiter Committee has decided to apply the treatment to *all* the elementary school children of the Valtellina, thanks to the timely assistance of the Italian Red Cross which is furnishing 80,000 chocolate drops, and of the *Istituto Sieroterapico Milanese* which has promised 100,000 more.

Meanwhile, at the Congress for the study of endemic goiter which took place in Sondrio on September 29, the Chief Inspector of the National Organization for Public Health informed the Antigoiter Committee that the government proposes to attack the experimental prophylactic treatment of endemic goiter in the Valtellina on a large scale, by selling iodized salt in place of common salt—both government monopolies—the proportion to be 1 gramme of potassium iodide to 100 kilos of salt.

The experiment if successful will be extended to the regions invaded by the disease.

GRACE BAXTER, R.N.

IMPRESSIONS OF THE PHILIPPINES AND OF SIAM

Notes from a talk on nursing developments in these countries given by Alice Fitzgerald

If some of our readers are as ignorant as "we"—editorially speaking—were of the countries mentioned in this account, they may welcome this section of the map of Asia.

THE nursing situation in the Philippine Islands is a surprise to the newcomer, as I think we hardly realize what progress has been made by the Filipinos in this field of activity.

There are fourteen training schools in the Islands, seven of which are in Manila. Some are government schools, others are Mission, Roman Catholic, or private. The largest is the one connected with the Philippine General Hospital established by American Army Nurses about eighteen years ago and which has been under Philippine management for the last nine years.

The standards of nursing education are high and are laid down by the state, which also registers nurses and midwives. The curriculum and the requirements for admission are similar to those in many of our states.

The Filipino woman takes to nursing very kindly. She is gentle, quiet, has much poise and inspires confidence in the sickroom. In the Philippine Islands, as in most of the Oriental countries, male nurses are trained with the women nurses and it is not unusual to have brother and sister enter the school at the same time. The male nurse, however, will find fewer openings as the years go on, as the women nurses are called upon to fill all the institutional positions. There is, however, an important field in which the male nurse is called upon for service, public health nursing in the outlying and remote districts, where it would not be safe to send a woman nurse.

With the establishment of the post graduate nursing course in the University of the Philippines, with excellent theoretical instruction and practical work provided, it is possible to train both young men and young women in the different branches of public health nursing before sending them out into the field. Public health nurses have been sent to all of the larger communities in the different Islands, but it will be many years before the supply can meet the demand.

The first public health nursing course graduated 30 nurses, the second one 69 and the third one has enrolled 34 students. The fourteen schools of the Islands graduated an average of 200 nurses. The number taking the public health nursing course seems to be a fair percentage of the whole.

Tribal Differences

There are several tribes in the Philippine Islands which differ very much from each other on account of their geographical position, habits and environment. In the mountain region of Luzon, we find the Igorotes, a mountain people to whom it has been very difficult to send any kind of medical or nursing help because of the distance and the difficulties in reaching their little communities. Furthermore, the young people were not willing to come down to Manila to train as nurses, partly because they fear the lowlands as a climate and do not feel at home away from their own people. It was therefore necessary to establish a training school for nurses nearer their homes and for this reason one was started in Baguio, a popular summer resort.

There are no means of transportation in the mountain regions and the Igorote boys and girls have to walk long distances, sometimes a whole week, with their few belongings slung on a

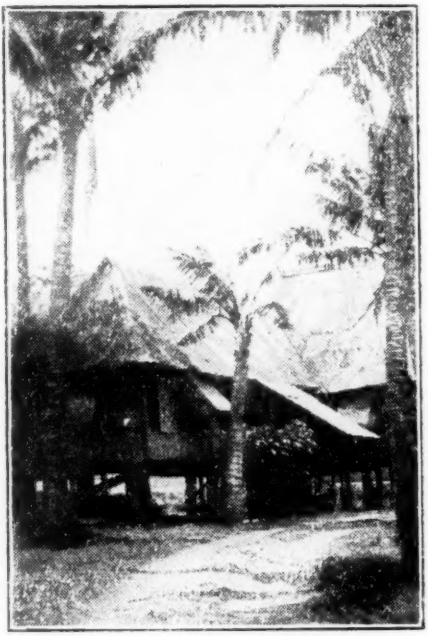
stick across their shoulders, in order to reach Baguio and have the one year of high school to gain admittance to the training school for nurses.

I was interested to see how quickly the mountain people adapt themselves to the discipline of their new life. A month after admission the Igorote boys and girls were performing their duties in the wards very much as our own probationers would be in this country.

Another tribe of the Philippine Islands, which differs greatly from all others, is the Moro tribe, which is a name given to the Mohammedan inhabitants of the Southern Islands. The Mohammedans are under the leadership of the Sultan of the Sulus, who lives in Jolo, the capital of the Island of Sulu. As is the case in other parts of the world, the Mohammedans do not approve of education for their daughters because of the custom of selling them in marriage at the early age of 12 or 13. Because of this it has been next to impossible to find Moro girls with sufficient education to enter the nursing schools. It has, however, been possible to enlist government interest. Scholarships are offered to Moro girls and boys to enable them to go to Zamboanga to secure the high school training as a preliminary to entering the nursing school in that city.

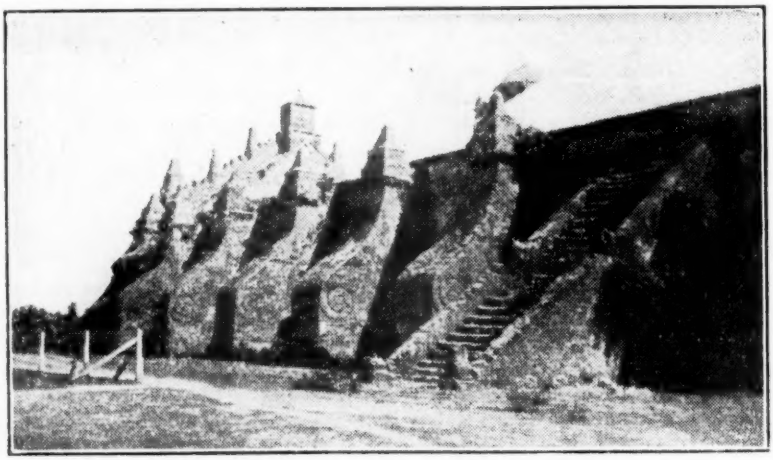
This scheme has also been applied to other non-Christian tribes which are to be found in the islands of Mindanao.

It will be seen that the general nursing situation in the Philippine Islands is progressing rapidly. The schools are good, public health nursing is developing rapidly and the rural districts are being educated in principles of hygiene and child welfare.



Typical better class Filipino residence

An interesting development to be found in the Islands consists in the training of midwives in special mater-



Old Spanish Church in Philippine Islands

nity centers. These centers generally consist of simple inexpensive buildings with about 12 beds and with equipment suitable to the training of midwives in the Philippines because it is more like the simple furnishings to be found in the native homes than the modern equipment usually found in hospitals. These maternity centers give a ten months' training to about 40 midwives and are in charge of two or three graduate nurses with sufficient obstetrical training.

Siam

Siam is a country little known to the average tourist because it is slightly off the beaten track. It is, however, more than well worth a visit.

The Siamese are of Malay origin, like the Filipinos, but the race has remained a purer type, as there has been less intermarriage, except with the Chinese. Siam is said to be the only country in the East which has retained its autocracy through long generations as it has never been conquered or placed under protection of any foreign power. The country is Buddhist and of course polygamous, and this accounts for the very large family connections, both among the higher and the lower classes of people. This is of advantage to the country because the royal family and its enormous connection have for many generations sent numbers of the men of the family to be educated at well known universities in England, France, Germany and Russia. Upon their return these men have taken an active part in administration. This constant bringing in of new and modern ideas from outside has had an excellent effect upon the country at large. It is interesting to note that with little or no stimulation from the outside this same method has applied to young women who have gone to foreign countries to study nursing and upon returning to Siam have founded two training schools for nurses, each in charge of a foreign trained nurse, and two welfare centers, also in charge of a foreign-trained Siamese nurse.

Statue in front of hospital in Zolo, Island of Sulu. A similar statue of a nurse protecting childhood has been erected in Zamboango. In this picture the figure of the child is a Moro.

The nursing situation is fairly satisfactory though still in an early stage. The Siamese Red Cross, which is an important organization commanding practically unlimited funds, is very active in developing nursing and finances a large hospital and training school in Bangkok, as well as two child welfare centers recently organized. Furthermore, the Siamese Red Cross has provided scholarships for four young Siamese women who are now taking their nursing training in Manila and who will take a post graduate course in public health nursing before returning to Siam.

Another training school at Bangkok is run in connection with the University Hospital to which is also attached the

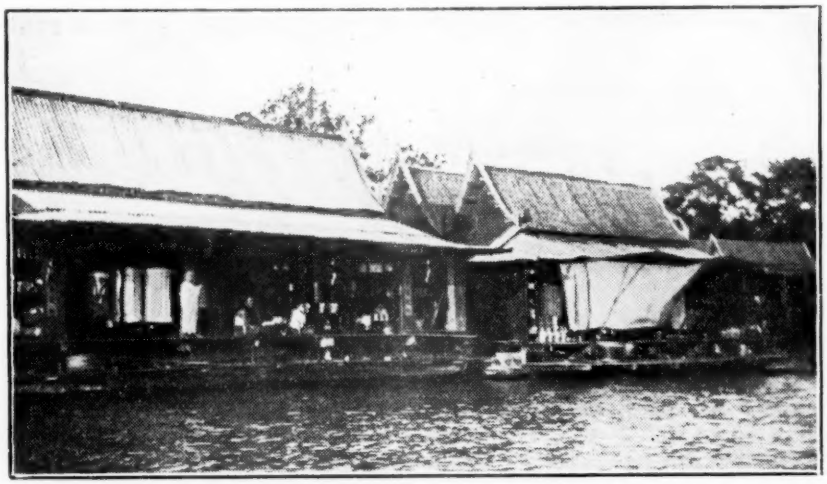
only Medical School of the country. In the Northern part of Siam the Presbyterian Mission has a hospital and training school which is directed by an American nurse.

The question of rank in Siam is extremely confusing to a foreigner. Promotion in rank, and this is a thing which can happen frequently to any individual, is accompanied by a change in name, so that one really never knows by what name to address a person, no matter how well one may know him personally.

In the training schools for nurses the question of rank at times becomes both difficult and confusing, and it is quite in the order of things that a student of higher rank, socially speaking, than her instructor might wish to assert her authority, in which case the instructor would be quite helpless. This is well illustrated by the fact that the Red Cross Hospital training school has as its nominal director a princess of the Royal family, whose duty consists mainly in enforcing discipline. The professional direction is in the hands of a trained nurse who told me that she would be helpless in the matter of enforcing discipline were it not for the presence and assistance of the Princess.

In spite of all such difficulties, the situation in Siam is hopeful and people have worked out problems for themselves in such a satisfactory way that it is evident that with a little outside help progress might be more rapid and results obtained more quickly.

Bangkok is called the Venice of the East because it is built on so many canals called Klongs. The shopping districts on these canals consist of stores which have been built up on pontoons. Shopping is done in a canoe or rowboat as it would be in Venice, though the landscape is somewhat different.



A shopping district on one of the Klongs

Of course, one cannot leave Siam without a mention of the wonderful temples which are to be found in the different parts of the country. The coloring of these buildings is perfectly wonderful. The detail work is quite surprising. The high pointed turrets, which are a part of the temple, are studded all over with pieces of broken porcelain or glass which have been worked like a mosaic into flower patterns, generally over every bit of the monument, often several hundred feet high. The sun reflected in these buildings makes an unforgettable impression.

The Siamese women wear short hair, cut just like a man. They also wear the same nether garment which consists of a strip of cloth bound around the hips with the point drawn up between the legs and tucked into the waist, which gives the effect, almost, of

a divided skirt. The men have adopted a different color for their trousers for each day of the week. Yellow is a color which is reserved entirely for priesthood. It is interesting to know that every man at some time during his life must be a priest, just as every man in some countries has to do military service.

Leprosy in the Islands and in Siam

There are a great many lepers in the Philippine Islands and also in Siam and it is interesting to know that entirely different methods are employed for their care in each country. In the Philippine Islands there is strict segregation of lepers. Consequently the lepers are not apt to report themselves for treatment because they know that it means a life sentence to the Island of Culion and separation from their families and friends, even though every care is provided for them in Culion. When the lepers are found in the different Islands, they are gathered together in camps or hospitals or prisons, until the collecting boat comes around to carry them to Culion. Finding the lepers is not an easy process as it is generally in purely accidental ways that these people are found.

In Siam, on the contrary, leprosy is not segregated and the patients report themselves freely for treatment or to be sent to the leper hospitals. Furthermore they bring with them friends or relatives who have the disease. The Red Cross runs a very excellent hospital for leprosy in Bangkok and at Chieng-Mai is to be found the leper colony established many years ago by Dr. McKean of the Presbyterian Mission who has devoted his life to this work. Dr. McKean and his work are so well known that it is unnecessary to say anything about him, except to state that his colony is a lasting monument to his perseverance in collecting funds and to his personal supervision of the colony. It is practically two villages, one for men and one for women. It is entirely governed by the lepers themselves. In Chieng-Mai and in Bangkok the lepers come and go as they please, enter the hospital and leave it when they feel better. The attendance at the leper dispensary is very large.

It would be interesting to know which of the two systems—complete segregation or the lack of it—produces the best results. It is obvious that they cannot both be right, nor can they both be wrong. The main thing is that in both countries every effort is made to make the life of these poor creatures less hideous.

Africa, where "darkness descends and rests on lovely skins until brown seems so luscious and natural," Africa of the simple life, beautiful and peaceful, is the theme of "The Primitive Black Man," written by Dr. W. E. Burghardt Du Bois, negro editor and author, for *The Nation*. "Wherefore shall we all take to the Big Bush?" he asks. "No. But my point is that New York and London and Paris must learn of West Africa and may learn. The one great lack in Africa is communication—communication as represented by human contact, movement of goods, dissemination of knowledge. All these things we have—we have in such crushing abundance that they have mastered us and defeat their real good."

"On the other hand, African life with its isolation has deeper knowledge of human souls. . . . Their intertwined communal souls therefore brook no poverty or prostitution—these things are to them ununderstandable. On the other hand, they are vastly ignorant of what the world is doing and thinking and of what is known of its physical forces. They suffer terribly from preventable disease, from unnecessary hunger, from the freaks of the weather. . . .

"All this beginning of trade and intercourse with the modern world is a matter which ought to call for the wisest thought and the most farseeing philanthropy. It is left to-day in the hands of the most selfish and ignorant white traders. One could envisage in West Africa a missionary effort that would uplift the world; trained physicians and nurses, masters of industrial processes guided by ideals which make industry cater to human development and uplift; wise men trained in anthropology and history to observe and copy the ancient and in many respects magnificent native organizations; and teachers who know how to teach."

HOW ONE ORGANIZATION SOLVED ITS AUTOMOBILE PROBLEM

EDITOR'S NOTE: We believe this survey of a question which is increasingly engaging the attention of boards of directors and executives of public health nursing organizations will be welcomed. The survey is now being extended to cover a full year, and this further material will be available in the spring.

We began in the department devoted to "Problems and Policies" in the December number a more general discussion of the main points involved in connection with Transportation, which is continued in this number.

FINDING themselves possessed of five cars in various stages of disrepair and faced with the need of increasing the use of automobiles by their nurses, the Denver Visiting Nurse Association appointed a committee to investigate the whole question of transportation. The following report was made by Mrs. Amos C. Sudler, chairman of the Automobile Committee, after an analysis of the situation and a study of the period beginning with December, 1923, and ending with June, 1924. The survey was made at the request of two organizations, one in the West and one in the East. Few organizations find the transportation problem an easy one to solve, and the careful survey and findings of the Denver committee are well worth noting.

To understand the situation, a brief review is necessary. When this committee began to work, the situation with our automobiles was crucial. We owned five Fords, aged respectively 9, 11, 13, 17 and 21 months. They were all in bad condition, showed hard usage and little care, and, for the past year, had cost an average of $79.00 per month per car. This included depreciation. There were several very noticeable difficulties. The cars were kept separately in cold garages wherever quarters could be found convenient to some nurse's home. The garage charges were from $6 to $8 a month. One nurse was made responsible for each car, at considerable inconvenience and at the cost of much of her time. She was supposed to get the car to and from the office on time, to see that it had oil, water and gas, and to have the battery attended to. There was no central authority to look after the condition and expense of the car, and the Superintendent's other important duties very naturally overshadowed this one. What no one looks after no one really cares much about and these cars showed their lack of care not only in their appearance but in the condition of their engines and their other mechanical needs. The life of a car had been only a year and a half to two years at most. Our oldest one, 21 months old, looked and acted as if it might fall to pieces at any moment. We were advised to turn it in, but we had no money for a new one. Faced by the fact that we needed more rather than less automobile service, we went to work.

The First Step

The first thing was to have the cars plainly marked and numbered in good sized letters, Visiting Nurse Association, 1, 2, 3, 4, 5, on both sides. That immediately gave them a standing in the eyes of their drivers and the community which they did not have before. Then, though it was necessary to pay higher garage rent, they were all put in a central garage easily accessible to the office. We were fortunate in enlisting the interest of a Ford agency, which agreed to keep the cars in its service station at $12.50 a month per car; $5.00 of this was to be used for service on each car—a general inspection every night, gas, oil, water, alcohol in radiators, tightening of steering wheel if needed, any slight adjustments, batteries tested and noting of any necessary repairs—in other words to provide a guarantee that the cars are ready for use for the nurses when they come for them in the morning. Chains and curtains are also to be put on if necessary.

This means a great deal to the efficiency of our service and the change

was noticed almost immediately in the time saved the nurses who often before had to come in from outlying districts to the service station. Instead of turning in our two oldest cars, we decided to spend some money on a general overhauling of them, and to put them back into service. We spent money on all of them to make their appearance better, straightened fenders, bought new fenders, new curtains, new lights in curtains and back (for they were all minus), new tops, had the dents removed from bodies. No new paint, alas, for we had to prove we could save some money first before they could be painted. However, with their new lettering and general fixing up they looked like different cars.

We then held several meetings, with tea served, with the nurses who drive, and asked their coöperation in careful driving and in careful record keeping. The superintendent of the service station even took the trouble to talk to them and to go out in each car with them. Coöperation of the nurses was given whole-heartedly, a good-natured competition between cars in expense and care has grown up, and as a result in seven months only one side light has been replaced, no fenders have been destroyed and in general the cars show the better care they are receiving.

We keep daily mileage cards, each nurse noting the mileage at the beginning and end of the day. We keep track of all calls made by the cars from the nurses' day sheets, on which they also note any use of the car besides nursing visits, such as carrying other nurses to clinics, welfare stations, transporting patients, or other use in line of duty, our cars having been put on a strictly commercial basis.

Efficiency Increased Almost 100 Per Cent

The garage slips for gas, oil, service, repair, etc., do not pass through the hands of the nurses but are given to the chairman of the committee weekly by the superintendent of the service station. Everything possible to keep down expense has been done, and yet nothing has been sacrificed that would keep the cars in good running condition at all times. We know we have greatly increased the efficiency of the cars; we know they are almost 100 per cent better as to condition and we also know that our two oldest cars which were given a good general overhauling have cost us the least per month for seven months. This fact has caused us to decide to keep these cars for some time at least before turning them in on new cars.

Now for figures. Our average mileage per car per month for all cars has been 667 miles. Our calls average per car 369. The average cost per car, which includes everything, garage, service, gas and oil, repairs, washing, insurance and depreciation, is $58.64, a saving of $21.00 a month per car, $105 per month for the five, at this rate $1,260 per year. Analyzed, this expenditure represents:

$32.64	gas, oil, repairs, tires, batteries
3.50	insurance
12.50	garage and service
10.00	depreciation
$58.64	

With an average mileage of 667 miles per car at a cost of $58.64, it costs us 8 and 7/10 cents per mile to run the cars. With an average number of calls of 369 per car, at a cost of $58.64, it costs us 15 and 8/10 cents per call. There have been for seven months an average of 14.2 nurses using the five cars. These costs are not low. Had all our cars been in A No. 1 condition at the beginning of this year, I believe we should have found a sharp reduction in cost per month. I still believe that before the end of the year our monthly average will be better. Repainting has become a sad necessity and the committee plans to have all the cars painted and relettered before the end of the year.

We also have had other cars, for three months, 3 full time and 1 half time car, and for the rest of the time, 2 full time and 1 half time car, at a cost of $35.00 per month per car. These cars belong to the nurses who

use them, no others using them. Full figures have also been kept on them. We find that the average mileage has been kept on them at the rate of 532 miles per car, at a cost of 6 and 6/10 cents per mile and an average of 236 calls per car at a cost of 15 and 3/10 cents per call, which shows as compared with the cost per call of our own cars only a difference of ½ a cent per call, a difference which is far less than we had supposed possible at the beginning of our investigation. This proves, so far at least, that whatever way is most convenient to secure transportation for the nurse, our own cars or ones rented from the nurses, the cost will figure about the same, about 15 cents per call. However it can be readily seen that as far as the actual need of all the nurses is concerned the car owned by the association is more efficient in that it serves more nurses, for some 14 nurses a month get the use of our five cars, or about 3 nurses to a car as compared to 1 nurse to a car in the rented cars.

As to actual figures to prove the efficiency of the nurse plus a car, as compared to the nurse with no car, such figures are very difficult to secure. The only way seems to be to have a nurse who uses a car cover her district for at least a month with car, and for a similar period without car, and compare figures. We feel quite certain that the cars do add greatly in many ways, in saving time for the nurses, in morale, and certainly in conserving the health of the nurses, but we have no basis as yet to prove these assertions in figures other than those our treasurer gave in her six months report.

According to this report, in the first six months of 1923, the total number of visits was 27,034, which were accomplished by 21 and 1/3 nurses with five Fords. This is an average of 8 and 1/10 visits per nurse per day. The cost of the cars was $1,574.10.

In the first six months of 1924 the total number of visits was 34,007 with 21 and 1/6 nurses, 7½ cars and two stenographers. If the cost of the stenographers were put into nurses they could be counted as 1¼ nurses, making a total of 22 and 5/12 nurses in 1924. In comparison, then, there were 6,973 more calls in the months of 1924, practically only one more nurse, and the number of calls per nurse per day was increased to 10 and 3/10 as compared to 8 and 1/10. The cost of having 2½ more automobiles however was only $434.17.

It may be of interest to know that we have during this period purchased 19 new tires, 21 new tubes and four new batteries aside from all other repairs.

It will be interesting to note how the average per car will be by the end of the year. It is our aim to have the cars in is perfect condition as possible to begin the new fiscal year in December, a state in which they certainly were not found at the beginning of this year.

We have been employing the concentrated scarlet fever antitoxin in some of the more severe cases of scarlet fever admitted to the Durand Hospital. Our series is not yet large enough to justify definite conclusions as to its value.

We had found that, if the antitoxin is given early in the disease, a definite fading of the rash is apparent within twenty-four hours, and there is an improvement in the toxic symptoms. So the antitoxin may be said to remove the toxic element of the disease, including the rash. The subsequent course depends on the local infection in the nose and throat.

The sinuses, glands and ears are frequently involved early in the disease. After enough antitoxin has been given to relieve the patient of the necessity for combating the toxemia, these local complications should receive careful attention.

Because complications may occur so early in scarlet fever, and the damage done by the disease is to be estimated not so much in the number of deaths as in the after effects, the importance of preventive immunization is apparent.

Concluding paragraphs of the paper on Scarlet Fever by George F. Dick, M.D., and Gladys H. Dick, M.D., published in the American Journal of Public Health, December, 1924.

COLLECTION AND DISTRIBUTION OF BREAST MILK

By Dorothy Rood

PRACTICALLY the whole country is awake to the fact that human milk is the best food for human babies and that breast feeding is necessary to save lives and to give the soundest possible health as a basis for future development. The article by Miss Helen Chesley Peck in the June Public Health Nurse ably describes the methods used in Minneapolis to stimulate and maintain maternal nursing. Similar methods are being used to an increasing extent throughout the country. Splendid results are being obtained in campaigns to promote breast feeding. In Minneapolis, hospitals are coöperating by teaching each mother, during her stay at the hospital, to express her milk and, as a result of the stimulation caused by this expression, she goes home with an oversupply. The usual reduction in supply caused by the resumption of household duties does not go below the baby's needs and many unnecessary weanings are avoided.

But with all these efforts and their excellent results, there still remains a relatively small but nevertheless important number of infants who cannot be fed by their own mothers' milk. Wet nurses are difficult to find and the expense is prohibitive except to the wealthy and to institutions. This has led to arrangements in a number of cities by which breast milk is made available to babies who need it by agencies who collect the milk from mothers who have more than their own babies require. The Detroit Wet Nurse Bureau was described at the biennial nursing convention last June. Some other organizations carrying on this work are the Clinic for Infant Feeding in Grand Rapids, Michigan, the Babies' Milk Fund Association of Cincinnati, Ohio, the Community Health Association of Boston, the Health Department of Rochester, New York, and the Children's Welfare Federation of New York City.

Much of the technique has been learned from the dairy industry. We know that the milk of a herd is more uniform than that from a single cow, and profiting by this experience all these agencies pool their entire supply of milk each day. The donors are urged to give the milk as a means of saving babies' lives, but the money earned is a no less potent inducement. The prices paid to the donors range from two to fifteen cents an ounce. Occasionally a woman is able to nurse her baby, care for her home and still earn more than she could if she neglected both and went out to work. One organization pays five cents more an ounce for each ounce over five in order to stimulate the donors to contribute as large an amount as possible. To safeguard the donor's own infant the mother must register it at an infant welfare station unless it is under the care of a private physician.

Technique of Collection

Practically all of this milk is expressed by hand, generally in the home by the donor herself. In one place the donors come to stations where they express their milk in booths open at one side and under the observation of a matron who teaches a cleanly technique and sees that the rules are enforced. The matron improves the occasion by talking on health subjects to the mothers. This organization does not sterilize the milk but advises that it be pasteurized in the home.

Organizations which collect the milk from the homes supply their workers with a special container in which the milk is kept on ice while being transported. The milk is pooled, sterilized, either by pasteurizing or boiling (the latter is most common method), put up in sterilized bottles to fill the orders and kept on ice. Usually the purchaser calls for each day's supply and there seems to be no provision for keeping it cool in the second transportation. However the time taken to carry the bottle

home is less than the time consumed in collecting from several homes. The prices charged range from three to thirty cents an ounce. All the organizations give the milk when the family cannot pay, and charge a fixed price somewhat below the maximum to institutions.

The supply is generally less than the demand. In some places the milk is taken away from the baby who is making the best progress and in others the amount given to each baby is cut down. All applicants should certainly be carefully investigated to justify discrimination. It seems altogether desirable to keep this service from commercialization. The dangers from dilution, adulteration and contamination are so great that the greatest care must always be used to safeguard the supply. Wassermann testing of donors does not seem to be necessary. Unless there is a syphilitic lesion on the breast there is very little chance of the spirochete being in the milk and this danger is absolutely overcome by pasteurization. Communication of the disease from a wet nurse is because she handles the baby.

Milk nursed by a baby directly from the breast is practically sterile but this cannot be claimed for milk supplied in any other way. Though the collection and distribution of breast milk is a work which saves many lives, it must never replace maternal nursing when this is by any means possible.

Dr. Harry B. Elkind has contributed two articles on allied topics to recent numbers of *The Journal of Industrial Hygiene*. An abstract of "Mental Hygiene in Industry" appears in the October issue of *Mental Hygiene*. According to the abstract Dr. Elkind refers to the identity of mental hygiene in industry and personnel administration. Both are concerned with the adjustment of man as an employee to his industrial environment and they differ only in the equipment and point of view of the workers in the two fields. Due to his background of medicine, psychology, sociology and economics, the mental hygienist brings to bear upon the human problems of industry a broader and more fundamental conception of the principles that determine human behavior and a more scientific technique in applying his knowledge. Trained usually along industrial or mercantile lines, such knowledge of human nature as the personnel worker possesses is empirical and his methods of handling his problems are based upon arbitrary judgments. But he is coming more and more toward the mental hygienist's position.

Since no definite program of personnel administration can be formulated until investigation and controlled experiment have shown just what are the problems in this field and what methods of attacking them are economically sound, a large mercantile establishment in Boston has organized a group of studies toward that end. One of these studies, conducted with a group known as the Junior Personnel, is reported in Dr. Elkind's paper. A group psychological test was given to this group, and a system of ratings by floor managers and department heads was installed with the object of correlating the results with the scores received in the psychological test. This was found impracticable but experience proves that it is a valuable personnel instrument in that it tends to keep both employees and executives in close touch with the employment department and to emphasize the question of personality in the minds of the executives.

As a result of his study Dr. Elkind feels that it is the employment department that has most need of the knowledge and the technique that mental hygiene has to offer. The problems involved in engaging or discharging individuals or in transferring them from one job to another are primarily problems of human adjustment and cannot be adequately handled without a full consideration of the physical, mental and social factors that enter into each case.

"Industrial Psychiatry," which was printed in the October issue of *The Journal of Industrial Hygiene*, is summarized by its author as follows:

Industrial physicians are beginning to realize the necessity of the psychiatric approach in the solution of their medical problems. This may be accomplished by a study of the personality and consideration of the mental, physical, and social factors. Many cases of functional nervous disease can be relieved or cured by this method. . . .

The recognition of minor deviations of personality are important from the point of view of prevention.

Industrial psychiatry is a specialized type of industrial medicine and has its application in factories, mercantile establishments, and industrial out-patient clinics. Industrial psychiatry is to industrial medicine what general psychiatry is to clinical medicine.

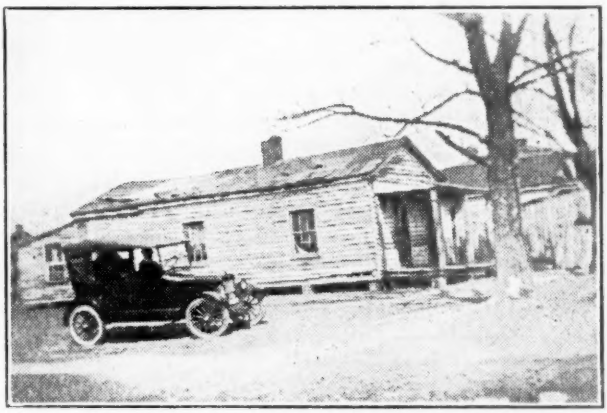
Industrial psychiatry must not be mistaken for mental hygiene in industry. The latter is primarily interested in the preservation of the heealth of workers in both mental and physical spheres.

A RURAL TRAINING CENTER FOR PUBLIC HEALTH NURSES

A NURSE cannot secure a diploma from an accredited training school without giving actual nursing care to sick people. Neither can she be prepared to do public health nursing without practical experience in the various phases of this type of work—she must have practice as well as theory. Heretofore the public health nursing experience has been too much confined to cities, with the result that such instruction as was given about rural conditions had to be mainly, if not exclusively, by means of lectures or visits of observation and without the aid of supervised field experience. In the public health nursing course offered in at least one school, here described, the attempt was made to give the student an insight into rural conditions by sending her away from the school to observe the work of a county nurse in other parts of the state. Experience has shown that this policy was disadvantageous for several reasons. By separating the students from the school it became impossible for the faculty to maintain adequate supervision over their work. Classes could not be carried on. Moving and giving up her room in the city was an added expense to the student. Moreover county nurses were too busy with their routine work to give sufficient time and energy for proper supervision and instruction.

Furthermore, county nurses usually devote their time each season of the year to different phases of their work. For this reason a student nurse must remain in the county for several months to obtain a comprehensive view of the year-round program. Finally, experience has shown that the students rarely do any actual work themselves under these circumstances but merely observe the county nurse.

In order to prepare the students as thoroughly for rural fields as for city districts, this school, with the coöperation and financial aid of the State Board of Health, organized in 1923 a rural teaching district in a section of an adjoining county. The district is in no sense suburban; is distinctly rural and is quite typical of rural conditions in this section of the country. A village with a population of about 250 is the largest community in the district.



Arriving to inspect children in one of the schools in the district

The training center was organized by a nurse who had graduated from an accredited course and subsequently had executive experience and rural experience.

Students are assigned to the district for twenty-eight hours per week for eight weeks. Transportation is by automobile or by electric car. The district itself is plentifully supplied with typical country roads and bypaths, so that the students learn the difficulties which they may expect to encounter in the way of transportation when they later go into their own respective fields.

The school has for several years been

planning just such a teaching center; accessible and at the same time typically rural. It is believed that the training district chosen meets most requirements. The district is accessible so that the student can keep her room in the city. Transportation facilities are satisfactory. The district is not large and the supervisor is able to adequately instruct the students and to plan their work so that each one will receive experience in the various activities of a county nurse.

Infant welfare and maternity work is carried on by the students under the direction of the supervisor, and methods of midwife education and control demonstrated. Reports are made and records kept on approved forms provided for this purpose.

There are eleven schools in the district, five white and six colored. Through the courtesy of the county superintendent the students visit these schools and, in coöperation with the teachers, inspect the children for physical defects, instruct in personal hygiene and in methods of preventing contagious diseases. They follow up the children by visits to the homes and arrange for correctional treatment. Nutrition classes are arranged when practicable. Methods of health education, applicable in the rural sections, are also demonstrated, and the technique of sanitary inspection of school premises and equipment is taught.

In addition to the work in the schools, observation and experience in other forms of public health work in rural districts is given. This includes inspection of sanitary conditions on the farm and in the home, home nursing classes, and the conduct of tuberculosis, infant welfare and dental clinics.

The training center as now organized is the result of four years of study and experience in planning the type of training that will be the most useful to the rural nurse in this section. The advice of national and state health authorities was sought. The graduates of the school were requested to offer from their own experience, suggestions for better preparation in rural work.

The effort has been made in planning the work of the center to demonstrate to the student nurse the methods of public health nursing demanded in rural sections, as distinct from suburban communities. The intention is to make it possible for the nurse to easily adapt herself to a rural position and to begin work immediately with the resources that are available, also to avoid that discouraging and expensive readjustment which comes to the student who has been trained to consciously or unconsciously rely upon the facilities of suburban and city communities. The rural nurse at present is a pioneer and in certain sections of the country it is desirable that her training should be arranged with this in mind.

The training center, therefore, is not a demonstration of the ideal methods in which work should be carried on in rural communities where conditions and resources are ideal or of the type of work which may be done in the next generation. It is a district for the training of nurses so that they will be able to meet present day problems in the most efficient manner and be able and willing to accomplish effective results with present day rural facilities.

However, training for work under the more favorable conditions which will doubtless come in the future is not neglected. This is given in the nearby city in which the school is situated, where public health nursing is well developed. In this way the student is taught through her work in the rural center methods of securing efficient results with the facilities which rural communities now have, and at the same time she is prepared to do her part in the development of better things in the future. It is felt that the success of the plan is demonstrated by the fact that of the eighteen students who took the course last year, thirteen went into rural fields.

EDITOR'S NOTE: This is a description of the Rural Training Center for Public Health Nurses in Virginia under the direction of the Richmond School of Social Work and Public Health.

NUTRITION WORK WITH A NURSING ASSOCIATION*

By Stella M. Dean

Nutrition Supervisor, Rochester Public Health Nursing Association

Fifth of the Series on Problems of Nutrition

IT IS INTERESTING to trace the development of Nutrition Work in the Rochester Public Health Nursing Association.

Four years ago one dietitian taught dietetics to the nurses and acted as consultant on special diets, budgets, etc. She also organized two nutrition classes for school children, one in a hospital and the other in an outlying district.

The next step was made when the Rotary Club asked the Public Health Nursing Association to take over the supervision of two milk stations. Dietitians were employed in the hope that some intensive nutrition work could be done with the families to whom milk was sold. But it was found that the best portion of the day was spent in selling milk and keeping accounts and records, and little was accomplished educationally.

The following year the experiment was tried of employing nonprofessional workers to carry on the routine of the milk stations, this time under supervision of one dietitian, who with this arrangement was able to concentrate her efforts on home visiting. Also the second dietitian was released for teaching in another district.

Thus, in the third year of our nutrition work our staff consisted of two milk station saleswomen, one visiting dietitian and one teaching dietitian. Last year another trained worker was added. This year with one milk station discontinued, we have one untrained worker only, and have added two more trained workers, so that in each of the five nursing districts we now have a dietitian, who makes her headquarters at the district office with the nurses, and helps them complete the health program for the families under their supervision.

All cases are "opened" and "closed" by the nurses, (1) because families are usually referred to the Association on account of an illness, and (2) in order to insure against the overlooking of health problems other than those of nutrition. Nutrition problems therefore, unless especially referred by the doctor must be detected by the nurse. This is one reason why nutrition instruction is included in the Association's course for public health nurses.

It is expected that every family in which there is an "active" member shall be visited at least once a month by both the nurse and the dietitian. Both may or may not be dealing with the same individual, but both visit the home, and the entire family is the concern of each from her own angle. Office conferences between workers are many, and sometimes home visits are made together.

Policies Governing Service

The general policies governing the nutrition service are those which govern the other work of the Association.

With regard to diagnosis and treatment, therefore, every effort is made to get the "patient" under medical supervision and only "emergency" service and general advice are given until specific orders have been obtained from a doctor.

Formula demonstration has been made a part of the nutrition service. Formulas are never prescribed or changed without the doctor's orders. No general standing orders nor standard diet lists having been officially approved by any local medical group, we are very conservative in the additions we suggest to the diet of children under one year. Similarly we try to get special diets individually prescribed by the private or clinic physician. Our

* Abstract of a paper read at the meeting of the American Dietetic Association, Swampscott, Massachusetts, October, 1924.

work in this line is thus made really authoritative.

Reference of a family to a social agency may be made by either the dietitian or nurse according to the individual situation and predominant problem. Families are frequently referred to the association by hospital social service departments and other agencies for the services of a nutrition worker in teaching foods for the family or planning a budget. Case conferences are often held to permit problems of the dietitian nurse and social worker to be presented for discussion and mutual aid.

Our record system is simple. The nutrition workers write daily reports, similar to those of the nurses, of home visits made. From the daily report sheets the notes are copied by typists on to the running record of the family history. The nurses' notes are copied in black, the dietitians' in red and all are entered in chronological order. Both workers may thus know at a glance what each is doing in the family. A separate nutrition index file is kept for the nutrition supervisor, to simplify counting up and checking on the families receiving an active nutrition service. Each worker has a file of field cards for her own families. Records of "active" families are all kept on file in the district offices.

Groups Served

Because our Association is financed by the Community Chest, and because the dietitians work only in families known to the nurses, our district work is limited to families eligible for dispensary care. Two of the five districts into which we divide Rochester are predominantly Italian, one Jewish, and the other two American.

As there are nutrition workers in the Rochester public schools, we are concerned with the school child only in case of home instruction regarding special diet. Following the policy of the Association much emphasis is placed on work for the expectant mother, the infant and preschool child. As our Association is concerned with the health of the family as a whole we deal also with general problems such as the budget and food for the family.

Our program is carried out by means of:

I. Demonstrations in the home—over 200 made last year.

II. Instructive home visits—2,686 visits made last year.

III. Coöperative calls with other agencies (by telephone or in person) —about 200.

IV. Conference with the nurses.

V. Classes.

a. For district mothers in the form of "clubs."

b. For mothers and "little mothers" of preschool children, always accompanied to the classes by the children.

We are responsible also for the nutrition program of class, laboratory and field work for the students in the 4 months public health nursing course and in the six weeks pediatrics course.

Summary and Future Development

Ours is not a perfect program. We are only in the process of developing a plan. We have found it a handicap not to work directly with the school child. It is obviously difficult to teach people whose standard of living is low. Not least among our needs at present, is greater knowledge of the preschool child.

Out of our experience in failure and success, there have come certain aims with which we face the future. We believe that one of the best aids in educating the foreigner is direct contact with him in his home. There is little the foreign mother will not believe if the nurse tells her, after she has once seen the wisdom of the nurse demonstrated. With this in mind, our nutrition department aims in the first place to do more and better work in

a larger number of district homes. In the second place, believing that group instruction is economical in time and effort, each nutrition worker is aiming to teach at least one group in whatsoever aspect of nutrition she considers best meets the need in her particular community.

SCHOOL NURSING ON A STATE-WIDE PLAN *

Everlasting team work between doctor, nurse and the community are at the bottom of the success which has met the state-wide school nursing plan adopted by the Florida State Board of Health early in 1924. Otherwise, conditions which make it necessary for one doctor and one public health nurse to cover a district of as many as fourteen counties might have proved insuperable. The state, comprising sixty-five counties, has been divided into five districts of from twelve to fourteen counties each.

Upon visiting a county the doctor and the nurse try to sell the idea of positive health to any one who does not seem quite convinced of its value. It sometimes seems that the chief requisite for a public health nurse is the gift of being a good salesman. Almost anyone could sell Fords or South Florida real estate, or something that people really want. But to sell positive health to people who still have the belief that there is no need for a doctor unless a person is seriously injured or has swallowed poison, nor for a nurse unless the victim is dying—that requires good salesmanship indeed.

We always make a point of calling upon the county superintendent of schools and enlisting his assistance. Usually he promises to supply a spot map of the county, locating the schools, giving the enrollment and the name of the teachers, and grouping the schools in such a way that we can accomplish the most work with the least travel. The Woman's Clubs and the Parent-Teacher Associations are also valuable aides.

I am very proud of a piece of work that has been accomplished in one little town. There was no organized body of women to appeal to, so we held a meeting of teachers and mothers to discuss the work. They became tremendously interested, and the plan for appointing a grade mother for each grade was enthusiastically received. So many mothers volunteered their services that we appointed three grade mothers for each grade. I was completely overwhelmed when I found that each teacher was in charge of two grades, which gave us six mothers to each room. But they were willing workers and we found work for all to do. Realizing the necessity for organization, the mothers decided to call a meeting to organize a Parent-Teachers Association. In consequence there is in this little town a body of people organized to carry on throughout the year the health work that has been started.

Merely finding defects and pointing them out to the parents is by no means the most important part of school nursing. It is even more necessary that the child shall be interested in his own handicaps and the parent stimulated to a belief in positive health. To achieve this end among the educated, thinking people of the community, to vet them to see the need for a local health unit and make appropriations to maintain it, that we consider our big accomplishment.

CORA BAERTSCH.

* Read before the annual meeting of the Florida State Nurses Association, November 18, 1924.

The Committee on Bathing Places presented a report to the Sanitary Engineering Section of the American Public Health Association at its meeting in Detroit. The conclusions of the committee—until further study is made—concerning precautions which may lower the incidence of bathing place infections are:

1. Maintenance of a clean environment.
2. Attempt to control the bathers' movements.
3. Advocate the use of bathing caps.
4. Advise against the long immersion and bathing period.
5. Advise against use of pool when sick or infected.

The committee in conclusion urges all energies and agencies to continue their studies and observations.

PUBLIC HEALTH SECTION, COLLEGE OF NURSING

Miss Hester Viney, Honorable Secretary of the Public Health Section of the College of Nursing, England, sends this statement of the purposes and aims of the Section.

THE Public Health Section of the College of Nursing was formed in order that the Council of the College might have an advisory committee to which it could refer matters of public health interest, to obtain expert advice on these questions.

The Section represents the trained nurses in public health service, and has been very active on their behalf since its inception.

With a rapidly growing membership the Section has acquired much influence. The Section has as its aims:

To promote post-graduate education among its members by means of "post-graduate weeks" organized in various parts of England;

To better the conditions under which public health nurses work, by means of letters and deputations to protest where cases of hardship are brought to the notice of the Section, and also where any local authority advertises a post for a nurse at a salary under £200 per annum;

To obtain a standard training and qualification for public health nurses, which will in the future be stabilized. and will thus be recognized by the authorities.

The Section has since its inception attacked the variable standard of training and efficiency permitted to women who are allowed to enter the Public Health Service, which is the main weakness of the public health administration of this country. It has made strong representations to the Ministry of Health for recognition that the basis of the training of women who enter Public Health Service should be that of the general training of a nurse at a recognized hospital, which will enable her to qualify for registration on the general part of the State Register maintained by the General Nursing Council of England and Wales. This qualification it is felt should be amplified by that of the certificate of a midwife, and by a year's course in public health work of the university standard. This should include sound instruction in the social and industrial problems which she will meet in her work, and also practical experience under such local authorities as have been approved as training bodies.

The conditions for approval as a training body insisted upon for the local authorities should be:

(1) That they are putting into action a comprehensive scheme of public health administration.

(2) That sound theoretical instruction is given to the candidates by the staff, and that the experience should include work actually undertaken by her under supervision.

(3) That the time of training under the local authority should be free of expense to the candidate herself, but that regulations should guard carefully against the possibility of the local authorities using cheap labor, or of their employing untrained workers to the detriment of the trained worker, and to the work undertaken by her.

The Section will hold bi-monthly meetings in the coming year.

The office of Industrial Hygiene and Sanitation of the Public Health Service has submitted a report to the Post Office Department recommending the adoption of a standard system of artificial illumination in all post offices. According to the report a technical study was made of two typical post offices, one modern and one of an older type. A study of the relationship between the volume of light and the eye strain on the workers showed figures heavily in favor of those employees working in the modern office, while speed tests in sorting and handling mails showed an increase of 4.4 per cent under adequate lighting.

From *The News Letter*, published in February, April, June and October by the National Committee for the Prevention of Blindness, 130 East 22d Street, New York City.

THE NECESSITY FOR TRAINING NURSES IN COMMUNICABLE DISEASE NURSING*

By Elizabeth F. Miller, R.N.

Nursing Consultant, Department of Welfare, Harrisburg, Pennsylvania

IN THE paper of Dr. Charles P. Emerson,† we have had not only a constructive vision of the whole problem of communicable diseases, but a new emphasis, and a new appreciation of our responsibility to interpret to succeeding ranks in our profession the new aspects of the problem.

With the vivid picture presented to us by Dr. Emerson, we approach the salient points of our discussion. What responsibility devolves upon the nursing profession, and how are we to meet it?

First, the acquisition of knowledge, second, the daily application of it in our personal lives, and in our professional activities. Where, how and when should this knowledge be obtained?

A survey shows the following fields where this education may be acquired:

The communicable disease hospitals of the country.
The tuberculosis sanatoria and clinics.
The venereal clinics.
The communicable disease departments of large general hospitals.
Affiliations with Visiting Nurse Societies caring for communicable disease patients.
Children's hospitals, and children's wards in our general hospitals where good technic in communicable disease nursing is taught.

Of the above mentioned resources, the communicable disease hospitals present the most promising fields. Considering these hospitals from the standpoint of teaching, we may discuss the function of these hospitals in the community, and the responsibility they should share in the control of communicable diseases.

The primary function of communicable disease hospitals is for the hospitalization of such patients who cannot be properly isolated in the home, but they have another vital function, the education of doctors and nurses in the care of the patients, and in the public health aspects of communicable diseases.

To accomplish these ends, such hospitals must be active teaching institutions, and avoid falling into monotonous routine. Dr. Winford Smith expressed the potentialities for service in these institutions when he said:

> To the community in which an institution of this kind is located it has an enormous educational value. The effect which the standards and principles of such an institution have on a community, the development of public interest in these principles, the effect of this group of workers, in disseminating knowledge concerning the transmission of disease, and its eradication, cannot fail to have a very practical value in the development of public hygiene, better sanitation, better living conditions, and a higher plane of existence.

Summarizing the functions of these hospitals, we would say their objects are:

> To provide medical and nursing care for those patients who cannot be isolated properly in their homes.
>
> They should have such medical and nursing standards as to make them effective exponents of the ideals of preventive medicine. Every line of effort exercised in the prevention of cross-infections is a protection against all other infections, and the care exercised in the admission of patients, the subsequent observations made, the daily vigilance exercised, constitutes a training that no doctor or nurse who is imbued with the modern ideals of public health can afford to lose.
>
> Such institutions can be made clearing houses, where not only the immediate infections can be cured, but an effective effort can be made to coördinate with the constructive activities of all other children's institutions and child welfare organizations. Many physical, nervous, and mental defects, which may have remained obscure for indefinite periods, may become accentuated during the period of these infections. To secure proper means for the correction of these defects is one of the inspiring motives that actuate the life and conduct of the work in these hospitals.

* Presented at General Session on Communicable Disease, Biennial National Nursing Convention, Detroit, Michigan, June 17, 1924. (Discussion of Dr. Charles P. Emerson's paper.)

† Printed in the September number.

The nursing profession has barely touched these hospitals from an educational standpoint. We register graduates year after year as fully fledged nurses who have never seen a rash, or a membrane, or had any contact with a tuberculosis patient.

In considering the communicable disease hospital as a teaching field, let us now consider some of the practical problems that confront us:

There are not sufficient communicable disease hospitals equipped for modern technic, and provided with an adequate teaching and supervising personnel.

Many hospitals are so remote from the communicable disease hospitals that the cost of transportation for students may make this training prohibitive.

There is a great variability in the types of cases admitted to these institutions. A hospital having a thousand cribs may be filled and yet only be able to give experience in the disease that happens to be epidemic, with here and there a few cases of diseases that are endemic. There is a great difference in the census of these hospitals in winter and in summer, so there may be a great difference in the amount of clinical material available for different groups.

This training for many years will have to be elective. Prejudice against this phase of nursing must be lived down in the minds of the parents of students.

The failure on the part of some communicable disease hospitals to extend their facilities to students. The reason for this is generally because it is less arduous to have a continuous nursing staff than an ever changing group such as we experience in a teaching hospital receiving students for three months periods. However, meeting this problem depends upon the mental attitude of those who direct these hospitals. If the hospitals can consider their service as a great teaching opportunity, and each successive group of students as a means of providing more nurses trained for our communities in the care and control of communicable diseases, especially if the students can include nurses engaged in any public health activity, they will not neglect to take advantage of this mighty opportunity.

There are many solutions to these educational problems, and many adaptations and extensions that can be made.

From surveys taken of available resources for teaching nurses, we know that in the United States and Canada we could give instruction based upon periods of three months to at least 4,000 more nurses a year. The communicable disease hospitals can also do a great deal to change the mental attitude toward the problem by conducting groups of student nurses through communicable disease wards, instruct them in the possibilities of caring for these patients by the application of Pasteur technic and show them practically that communicable diseases are not controlled by " beating the air " processes.

Institutes on communicable diseases, and periods of observation for groups, such as public health nurses who have not had this training and students in public health nursing departments of universities and other schools, may also be conducted and prove helpful to nurses unable to give full time to the course. I believe that all universities and schools offering public health nursing courses should have some practical program on the care of communicable diseases, and should feel a responsibility for stimulating a proper mental attitude and interest in this essential part of the equipment of a public health nurse.

I believe that the education of the public through a public health nursing staff is one of the most important phases of public activity in the prevention of disease, and that in any public health program the very foundation of its success depends upon its nursing service. The opportunity of contact with parents and teachers that is the privilege of nurses who assume the care of communicable disease patients in homes cannot fail to inspire more coöperation in the isolation of the patients and a greater interest in the accepted methods of controlling disease.

PERSONALITY TERMS COMMONLY USED IN RECOMMENDATIONS

EDITOR'S NOTE: Nurse executives who are constantly being called upon to furnish estimates of nurses who have worked under their supervision will perhaps find this brief abstract of Professor Jones' paper interesting.

"Any careful attempt to evaluate the various criteria of ability used in hiring or recommending candidates for employment leads to one unmistakable conclusion: the ordinary *objective* scores from school grades or intelligence tests are inadequate. One must inevitably fall back on *subjective* data, on judgments made by teachers, employers or others, regarding such characteristics as energy, reliability, insight, etc.," writes Edward S. Jones of the University of Buffalo in a recent issue of the *Journal of Personnel Research.*

Of the two ways of handling these subjective judgments, one, according to Mr. Jones, is known as the rating scale method, which considers only those specific traits or characterizations of personality which are obviously most significant and which satisfy the chief vocational demands of a position. This information discloses the most appropriate "rubrics of personality" for a specific occupation.

Experimenters with the rating scale method have found that moral traits are apt to be rated too leniently and without sufficient care. There are many ambiguous terms widely used which are almost valueless as measures. When members of the faculty (mostly men) in a coeducational institution judge students, the ratings given women are on the average far higher than the ratings given men. For most traits there is better agreement among the instructors on judging men.

Practical disadvantages of this method are the restrictions it places upon the teacher or employer who is asked to judge, so that a judge asked to give many estimates of students is fairly sure to do one of two things: either to delay the task of making estimates (or sidetrack it completely) or docilely to become a mechanical recorder, hurrying through the task with a minimum of thought and a maximum of "halo" influence, marking those whom he likes high in all traits and those whom he dislikes low. The use of a small set of traits for rating also interferes with the expression of fine shades of meaning, or the mention of special traits or aspects of the same general trait which are sometimes important to differentiate.

The average superintendent or other employer prefers to look at the free, unlimited type of confidential statement, which may be called the second way of handling subjective judgments. He seems to feel that the free statement is more human. He finds it easier to read between the lines. The amount of information volunteered is felt to be of some value, as a few very general remarks made in a perfunctory way have no meaning, whereas detailed qualifications and the citing of specific instances are greatly sought after.

In his study of this method, the traits or characterizations of personality chosen were taken from a careful survey of about 500 ordinary, uncontrolled confidential recommendations of seniors written by members of the faculty of Oberlin College. The members of two advanced groups of students in psychology, all seniors, were asked to judge members of their own class, using these characterizations.

Interesting points were brought out in this study. It was found that men rating men tend to rate higher, with the same instructions, than do women rating women; and the men agree better. It developed that women are less interested in the actual efficiency of others than they are in the *attitude* others take. Traits which were high for men, but low for women, were "adaptable, breadth, dependable, neat, steady." Traits which were low for men, but high for women, were "alert, bright, earnest, forceful, sincere." "Scholarship" and "ability" were the two traits referred to most frequently out of the list of eighty terms. *Objective* traits were found to be relatively

better agreed upon than *subjective* traits. Men were rated relatively higher in the intellectual traits and the nonmoral social[1] traits. Women were rated very poorly in traits of social control,[2] and in the general social traits they were not placed high by women judges. When men judges rate college women the results are quite different. They rate women about as highly, in proportion to men, in the social traits and in general intelligence, as they rate them on the average in various traits. Women are much more critical as to intellectual and social traits, though they are quite lenient in their ratings of the moral-social[3] traits, indicating that they are not entirely antagonistic to their kind. When women judge women the general intellectual traits are quite well agreed upon, while traits signifying special intellectual abilities show almost complete lack of agreement.

[1] Non-moral social traits include: Adaptable, Agreeable, Charming, Coöperative, Friendly, Genial, Independent, Kindly, Modest, Popular, Social Mixer, Tactful, Winning Personality, Poise.
[2] Traits of social control include Executive Ability, Forceful, Influential, Inspires Confidence, Leadership.
[3] Moral-social traits include: Character, Altruistic, Conscientious, Dependable, Earnest, Faithful, High Ideals, Honest, Loyal, Reliable, Steady, Trustworthy, Sincere, Unselfish.

SPEED SENSE

"Careless, reckless and pigheaded fools" must continue to reap the harvest they have sown, but to those motorists who flatter themselves that their sense of caution is fairly well developed, *Health*, published by the New Hampshire State Board of Health, presents an idea of "speed sense," which is distinctly novel.

Few people have any idea or sense of distance in terms of feet per second. Even accommodation trains, between stations, usually maintain a speed of 30 to 35 miles an hour, 51 feet a second. Visualize a distance of 300 feet. A train going 35 miles an hour would traverse that distance in six seconds, while an express train, running at 60 miles per hour, 88 feet per second, would cover the distance in three and a half seconds. If this simple arithmetic of grade crossings were fully understood by all who drive automobiles, few would make fatal misjudgment of distance and persuade themselves that "there is time enough to get past."

This arithmetic applies also on curves, especially on sharp curves. But here we have another danger which very few people understand. This is the centrifugal reaction, the outward push of cars driven around a curve at speed. Consequently if a driver of car attempts to take an ordinary road curve at high speed, one of three things will happen, especially if the curve be sharp:

1. If he misjudges the speed and does not turn quickly enough, of course the car will run off the roadway.

2. If the turn is too quickly made by the steering wheel the inner wheels will move too fast for the inside of the turn and the outer wheels too slow for the outside of the turn. The centrifugal push will throw the greater part of the weight of the car on the outer wheels and tend to lift the car outward. If the road surface is slippery the car will skid, especially if a heavy one; and if it then strikes an obstruction it will be likely to overturn—almost surely so if the car is not heavy.

3. If the road surface is rough, or just high enough to prevent skidding, then a light car may easily overturn in its own track, while a heavy car may run wholly on the outer wheels and bring excessive pressure and wear upon the outer tires. Excepting cars which go off down an embankment nearly all overturns are on curves.

This shows the great importance of the rule to "slow down on curves." If everyone who presumes to drive an automobile had a deep sense of responsibility for the safety of himself and those with him he would be governed by the principle which includes all others, to wit: "Play safe and take no chances." In a smaller degree his or her responsibility is greater than that of a locomotive engineer; for the latter, with his engine on the rails, has no steering to do; and his fireman may ring the bell and blow the whistle. But the driver of an auto has to or needs to attend to many things at once, and the neglect of any one may bring disaster. And yet we see young girls and reckless irresponsible boys driving automobiles—a menace to the safety of the public. Our boasted liberty and freedom are too much overdone.

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Edited by ANNE A. STEVENS

CREDIT FOR DETAIL WORK ON V. N. A. REPORT

Many of our readers on reading the Report of the Committee to Study Visiting Nursing must have raised the question in their own minds as to "who were the workers responsible for the detail of this report." Through an unfortunate oversight, the members of this most important group, though previously mentioned in THE PUBLIC HEALTH NURSE, were omitted in the published report.

Miss Almena Dawley, Supervisor, Department of Social Investigation of the Pennsylvania School of Social and Health Work, directed the details of the collection of the data, and organized and assembled this material for the report. Theresa Kraker, Associate Director of the N.O.P.H.N., and Janet Geister, Assistant Secretary, Associated Out-Patient Clinic of the City of New York, were responsible for the field investigations on which the report is based. Mr. Walter F. Derry, a public accountant, and Miss Lefa Nay, Chief Accountant for the National Health Council, collected from each agency a complete picture of their accounting systems and methods.

PRESCHOOL SERVICE DISCONTINUED

To live within one's income is the duty of every sane man. It is equally the duty of every organization. Much to our regret this means the discontinuance of our preschool advisory service, as a result of the curtailment of the budget of the American Child Health Association which has been financing this service.

Miss Rood left the organization on January 22. She brought to us such a knowledge of preschool child health nursing, and gave our problems such studious consideration, that we shall miss her participation in our work.

Miss Rood goes to the Instructive Visiting Nurse Society of Washington, D. C., as Educational Director. Our good wishes for her future will go with her.

SALARIES OF PUBLIC HEALTH NURSES

"How do our salaries compare with those of similar organizations?" or "What is the beginning salary for staff nurses?" are questions being asked continually by public health nursing organizations. To be able to answer these and other questions about salaries of public health nurses a questionnaire was sent, November 28, 1924, to 123 organizations in all parts of the United States and employing different numbers of full-time graduate nurses. This list includes 24 official organizations, such as City Health Departments, and 99 non-official organizations, that is, Visiting Nurse Associations and similar organizations. Twenty-one official organizations and 85 non-official organizations have returned the questionnaires, giving the information asked.

The questionnaire asked for data regarding salaries paid on November 30, 1924, to all members of the nursing staff, executives, supervisors, and staff nurses. The policy of increases for all members of the organizations for 1924 and any changes in this policy for 1925 were also requested. This information, in so far as it is complete and in a form available for tabulation, has been tabulated.

The organizations reporting have been classified first into official and non-official organizations and then into six groups, depending on the population of the city in which they are located. The organizations under each of these population groups are further classified into four divisions, depend-

ing on the number of full-time graduate nurses employed, executives, supervisors, and staff nurses.

The cities from which questionnaires were received, arranged by size of population, are:

Cities of 700,000 or more population:
New York, N. Y.
Chicago, Ill.
Philadelphia, Pa.
Detroit, Mich.

Cities of 200,000 to 700,000 population:
Pittsburgh, Pa.
Los Angeles, Calif.
Buffalo, N. Y.
Milwaukee, Wis.
Washington, D. C.
Minneapolis, Minn.
Kansas City, Mo.

Cities of 100,000 to 200,000 population:
Omaha, Neb.
Worcester, Mass.
Birmingham, Ala.
Syracuse, N. Y.
New Haven, Conn.
Dayton, Ohio.
Bridgeport, Conn.
Hartford, Conn.
Scranton, Pa.
Springfield, Mass.

Cities of 50,000 to 100,000 population:
Elizabeth, N. J.
Erie, Pa.
Waterbury, Conn.
Oklahoma City, Okla.
Savannah, Ga.
Peoria, Ill.
South Bend, Ind.
Portland, Me.
Charleston, S. C.
Johnstown, Pa.

Cities of 25,000 to 50,000 population:
York, Pa.
Charlotte, N. C.
Pittsfield, Mass.
Lexington, Ky.
Stamford, Conn.
Kalamazoo, Mich.
Orange, N. J.

Cities and areas of less than 25,000 population:
Concord, N. H.
Attleboro, Mass.
Santa Barbara, Calif.
East Orange, N. J.
Middletown, Conn.
Cleveland, Ohio.
St. Louis, Mo.
Boston, Mass.
Baltimore, Md.
Indianapolis, Ind.
Rochester, N. Y.
Denver, Colo.
Toledo, Ohio.
Providence, R. I.
Oakland, Calif.
Akron, Ohio.
Des Moines, Ia.
New Bedford, Mass.
Fall River, Mass.
Norfolk, Va.
Albany, N. Y.
Lowell, Mass.
Wilmington, Del.
Cambridge, Mass.
Reading, Pa.
Kansas City, Kans.
Brockton, Mass.
Rockford, Ill.
Pawtucket, R. I.
Terre Haute, Ind.
Holyoke, Mass.
New Britain, Conn.
Racine, Wis.
Long Beach, Calif.
Augusta, Ga.
Wilmington, N. C.
New Brunswick, N. J.
Columbus, Ga.
Moline, Ill.
Mansfield, Ohio.
Plainfield, N. J.
Morristown, N. J.
Mount Kisco, N. Y.
Ardmore, Pa.
Bernardsville, N. J.

Salaries of Non-official Public Health Nursing Organizations

Table I* gives the salaries paid by non-official public health nursing organizations to all members of the organizations classified by population of the city in which the organization is located and by the number of full-time graduate nurses employed in the organizations including executives, supervisors, and staff nurses.

The first division of the table applies to salaries paid to directors; the second, to salaries paid to assistant directors; the third, to salaries paid special supervisors; the fourth, to salaries of district supervisors; and the fifth, to salaries paid staff nurses.

The first row of each division of the table, with the exception of the totals in columns (2), (7), (11), (15), and (18), show the number of nurses

* See pages 98 to 101 for tables.

about whose salary information has been received arranged by the number of full-time graduate nurses employed in the organization. The numbers in these columns and also (21) are the total number of nurses in each of the six population groups, whose salaries are known. The remaining rows of each division indicate the number of nurses receiving the monthly salary as given in column (1).

Columns (2), (7), (11), (15), (18), and (21), with the exception of the first row of each division, give the total number of nurses, receiving the salary listed in column (1), in each population group. The other columns, omitting column (1), give the number of nurses receiving the salaries as listed in column (1) by number of full-time graduate nurses employed in the organization.

For example, in division 1. Salaries Paid Directors, 3 nurse directors out of a total of 13 directors in organizations employing 50 or more nurses, 25 to 49 nurses, 10 to 24 nurses, and 2 to 9 nurses, in cities of 700,000 or more population receive $375 a month. Two of the directors are in organizations employing 50 or more nurses and one, in an organization employing 25 to 49 nurses.

Using this table any public health nursing organization can compare the salaries which it pays with those paid by other organizations located in cities of the same size and having the same number of nurses.

Some interesting facts are shown by Table I: For instance, the highest salary of a director reported is $375 a month and the lowest is $135, for all numbers of nurses employed and in all size cities.

Under division 5. Salaries Paid Staff Nurses, we find that two nurses are receiving $175 a month. These two nurses are each doing special work and may be considered as a special group. Since most of the organizations in the south have a separate salary schedule for white and colored nurses, these colored nurses, for the time being, must be considered as a special group when considering salaries. If the salaries for these two groups, one high and the other low, were included, a false average would result.

Additional salary information will appear in the March issue.

L. M. T.

We will print in the March number a complete report of the Rhode Island Census as an example of the information which will be available for each state as soon as the census for that state has been completed.

N.O.P.H.N. PINS

Requests for pins should be sent as heretofore to the N.O.P.H.N. A letter of authorization will then be furnished applicants for pins, which they may send, together with their check, to Mr. W. Wallace Hurd, Room 1507, 9 Maiden Lane, New York, official jeweler to the N.O.P.H.N. Mr. Hurd will then fill their order, sending the pin direct to them instead of to the N.O.P.H.N. as formerly.

The rolled gold pins sell for $3.10 and the solid gold for $7.35.

MAGAZINES ON HAND

Anyone desiring single copies of the magazine, with the exception of the following numbers:

1909—January–October
1910—January–April–July
1912—January
1913—January
1914—January–October

may purchase them from the N.O.P.H.N. for 35c a copy.

Complete sets for the following years, 1911, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, may be purchased bound or unbound.

These will not be available after April 1.

TABLE I. SALARIES PAID IN SELECTED NON-OFFICIAL PUBLIC HEALTH NURSING ORGANIZATIONS, November

Salaries tabulated

1. SALARIES

Monthly salary	Cities of 700,000 or more					Cities of 200,000 to 700,000				Cities of 100,000 to 200,000			
	Total	No. receiving specified salary in organizations with—				Total	No. receiving specified salary in organizations with—			Total	No. receiving specified salary in organizations with—		
		50 or more nurses	25 to49 nurses	10 to24 nurses	2 to 9 nurses		50 or more nurses	25to49 nurses	10 to24 nurses		25 to49 nurses	10 to24 nurses	2 to 9 nurses
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Total	13	5	4	3	1	11	3	6	2	17	3	12	2
$375.00	3	2	1	....	....	....	....	....	....	....	....	....	....
350.00	1	....	1	....	....	....	....	....	....	....	....	....	....
335.00	3	2	....	1	....	....	....	....	....	....	....	....	....
330.00	....	....	....	....	....	1	1	....	....	....	....	....	....
300.00	1	....	1	....	....	3	1	2	....	....	....	....	....
290.00	....	....	....	....	....	....	....	....	....	2	....	2	....
275.00	....	....	....	....	....	....	....	....	....	....	....	....	....
250.00	3	1	....	2	....	3	1	2	....	2	1	1	....
235.00	....	....	....	....	....	....	....	....	....	1	....	1	....
225.00	....	....	....	....	....	1	....	1	....	2	....	2	....
220.00	....	....	....	....	....	1	....	....	1	....	....	....	....
215.00	....	....	....	....	....	1	....	....	1	....	....	....	....
210.00	....	....	....	....	....	....	....	....	....	6	2	3	1
205.00	....	....	....	....	....	....	....	....	....	....	....	....	....
200.00	2	....	1	....	1	1	....	1	....	2	....	2	....
195.00	....	....	....	....	....	....	....	....	....	....	....	....	....
190.00	....	....	....	....	....	....	....	....	....	....	....	....	....
185.00	....	....	....	....	....	....	....	....	....	....	....	....	....
180.00	....	....	....	....	....	....	....	....	....	....	....	....	....
175.00	....	....	....	....	....	....	....	....	....	....	....	....	....
170.00	....	....	....	....	....	....	....	....	....	....	....	....	....
165.00	....	....	....	....	....	....	....	....	....	....	....	....	....
160.00	....	....	....	....	....	....	....	....	....	....	....	....	....
155.00	....	....	....	....	....	....	....	....	....	....	....	....	....
150.00	....	....	....	....	....	....	....	....	....	2	....	1	1
135.00	....	....	....	....	....	....	....	....	....	....	....	....	....

2. SALARIES PAID

Total	8	3	1	4	—	10	4	5	1	12	4	7	1
$250.00	2	1	....	1	....	1	1	....	....	....	....	....	....
225.00	1	....	....	1	....	....	....	....	....	....	....	....	....
210.00	1	1	....	....	....	1	1	....	....	....	....	....	....
200.00	1	....	....	1	....	3	1	2	....	1	1	....	....
195.00	....	....	....	....	....	....	....	....	....	....	....	....	....
190.00	1	....	....	1	....	....	....	....	....	....	....	....	....
185.00	1	1	....	....	....	....	....	....	....	....	....	....	....
180.00	....	....	....	....	....	....	....	....	....	....	....	....	....
175.00	....	....	....	....	....	5	1	3	1	3	1	2	....
170.00	....	....	....	....	....	....	....	....	....	....	....	....	....
165.00	....	....	....	....	....	....	....	....	....	1	....	1	....
160.00	....	....	....	....	....	....	....	....	....	1	1	....	....
155.00	....	....	....	....	....	....	....	....	....	....	....	....	....
150.00	1	....	1	....	....	....	....	....	....	5	....	4	1
140.00	....	....	....	....	....	....	....	....	....	....	....	....	....
135.00	....	....	....	....	....	....	....	....	....	....	....	....	....
120.00	....	....	....	....	....	....	....	....	....	1	1	....	....

3. SALARIES PAID

Total	25	15	7	3	—	29	17	9	3	19	6	13	—
$235.00	2	....	2	....	....	....	....	....	....	....	....	....	....
225.00	....	....	....	....	....	1	1	....	....	....	....	....	....
215.00	1	....	1	....	....	....	....	....	....	....	....	....	....
210.00	1	1	....	....	....	....	....	....	....	....	....	....	....
200.00	1	....	....	1	....	2	2	....	....	....	....	....	....
195.00	....	....	....	....	....	....	....	....	....	....	....	....	....
190.00	....	....	....	....	....	....	....	....	....	....	....	....	....
185.00	4	4	....	....	....	....	....	....	....	....	....	....	....
180.00	....	....	....	....	....	....	....	....	....	....	....	....	....
175.00	3	1	1	1	....	....	....	....	....	1	....	1	....
170.00	....	....	....	....	....	....	....	....	....	1	1	....	....
165.00	4	2	2	....	....	3	2	1	....	1	....	1	....
160.00	....	....	....	....	....	3	....	3	....	1	....	1	....
155.00	....	....	....	....	....	....	....	....	....	....	....	....	....
150.00	6	6	....	....	....	8	5	2	1	2	2	....	....
145.00	1	1	....	....	....	1	....	1	....	....	....	....	....
140.00	1	....	1	....	....	8	6	2	....	2	1	1	....
135.00	1	....	....	1	....	....	....	....	....	1	1	....	....
130.00	....	....	....	....	....	....	....	....	....	....	....	....	....
125.00	....	....	....	....	....	3	1	....	2	9	1	8	....
120.00	....	....	....	....	....	....	....	....	....	....	....	....	....
115.00	....	....	....	....	....	....	....	....	....	....	....	....	....
110.00	....	....	....	....	....	....	....	....	....	1	....	1	....

CLASSIFIED BY POPULATION GROUP AND NUMBER OF FULL-TIME GRADUATE NURSES EMPLOYED
30, 1924
to nearest $5.00

PAID DIRECTORS

Cities of 50,000 to 100,000			Cities of 25,000 to 50,000			Cities of less than 25,000
	No. receiving specified salary in organizations with—			No. receiving specified salary in organizations with—		No. receiving specified salary in organizations with—
Total (15)	10 to 24 nurses (16)	2 to 9 nurses (17)	Total (18)	10 to 24 nurses (19)	2 to 9 nurses (20)	2 to 9 nurses (21)
11	4	7	9	3	6	7
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
1	....	1	....	....	....	....
....	....	....	....	....	....	....
1	1	....	....	....	....	1
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2	1	1	2	1	1	....
4	....	4	3	1	2	2
....	....	....	....	....	....	1
1	1	....	....	....	....	1
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1	....	1	....	....	....	....
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1	1	....	2	1	1	....
....	....	....	1	....	1	....
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....	....	....	....	....	....	2
....	....	....	1	....	1	....

ASSISTANT DIRECTORS

3	2	1	2	1	1	1
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SPECIAL SUPERVISORS

2	—	2	4	3	1	
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1	....	1	1	1	....	....
1	....	1	....	....	....	....
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TABLE I

4. SALARIES PAID

Monthly salary	Cities of 700,000 or more					Cities of 200,000 to 700,000				Cities of 100,000 to 200,000			
	Total	No. receiving specified salary in organizations with—				Total	No. receiving specified salary in organizations with—			Total	No. receivingspecified salary in organizations with—		
		50 or more nurses	25 to49 nurses	10 to24 nurses	2 to 9 nurses		50 or more nurses	25 to49 nurses	10 to24 nurses		25 to49 nurses	10 to24 nurses	2 to 9 nurses
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Total	48	35	11	2	—	45	28	15	2	13	8	5	—
$190.00	1	....	1	....	....	....	....	....	....	....	....	....	....
185.00	....	....	....	....	....	....	....	....	....	....	....	....	....
180.00	1	1	....	....	....	....	....	....	....	....	....	....	....
175.00	7	5	....	2	....	....	....	....	....	....	....	....	....
170.00	1	....	1	....	....	....	....	....	....	2	1	1	....
165.00	8	7	1	....	....	1	1	....	....	3	3	....	....
160.00	5	2	3	....	....	1	1	....	....	....	....	....	....
155.00	....	....	....	....	....	3	3	....	....	....	....	....	....
150.00	24	19	5	....	....	11	5	6	....	2	2	....	....
145.00	....	....	....	....	....	1	....	1	....	....	....	....	....
140.00	....	....	....	....	....	10	7	3	....	1	....	1	....
135.00	1	1	....	....	....	9	2	5	2	2	....	2	....
130.00	....	....	....	....	....	....	....	....	....	....	....	....	....
125.00	....	....	....	....	....	9	9	....	....	1	....	1	....
120.00	....	....	....	....	....	....	....	....	....	1	1	....	....
115.00	....	....	....	....	....	....	....	....	....	1	1	....	....

5. SALARIES PAID

Total	535	350	109	63	8	464	197	225	42	257	97	147	13
$175.00	2	....	....	....	2	....	....	....	....	....	....	....	....
170.00	....	....	....	....	....	....	....	....	....	....	....	....	....
165.00	....	....	....	....	....	....	....	....	....	....	....	....	....
160.00	....	....	....	....	....	....	....	....	....	....	....	....	....
155.00	....	....	....	....	....	....	....	....	....	....	....	....	....
150.00	52	21	....	25	6	....	....	....	....	....	....	....	....
145.00	22	....	20	2	....	2	....	2	....	4	....	3	1
140.00	57	40	7	10	....	16	1	15	....	2	....	2	....
135.00	66	53	2	11	....	2	....	2	....	3	....	3	....
130.00	92	51	34	7	....	17	4	13	....	1	....	1	....
125.00	104	77	18	9	....	182	80	98	4	7	....	7	....
120.00	70	57	10	3	....	52	17	26	9	27	7	16	4
115.00	54	35	18	1	....	88	41	39	8	51	22	29	....
110.00	6	6	....	....	....	52	33	13	6	70	37	33	....
105.00	10	10	....	....	....	19	12	....	7	56	15	33	8
100.00	....	....	....	....	....	34	9	17	8	8	4	4	....
95.00	....	....	....	....	....	....	....	....	....	21	12	9	....
90.00	....	....	....	....	....	....	....	....	....	....	....	....	....
85.00	....	....	....	....	....	....	....	....	....	....	....	....	....
80.00	....	....	....	....	....	....	....	....	....	....	....	....	....
75.00	....	....	....	....	....	....	....	....	....	....	....	....	....
70.00	....	....	....	....	....	....	....	....	....	1*	....	1*	....
65.00	....	....	....	....	....	....	....	....	....	....	....	....	....
										6*	....	6*	....

*Colored nurses.
**2 colored nurses.

(Continued)

DISTRICT SUPERVISORS

Cities of 50,000 to 100,000			Cities of 25,000 to 50,000			Cities of less than 25,000
Total	No. receiving specified salary in organizations with—		Total	No. receiving specified salary in organizations with—		No. receiving specified salary in organizations with—
	10 to 24 nurses	2 to 9 nurses		10 to 24 nurses	2 to 9 nurses	2 to 9 nurses
(15)	(16)	(17)	(18)	(19)	(20)	(21)
3	1	2	2	—	2	1
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
2	1	1	1	....	1	1
....	....	....	....	....	....	....
....	....	....	....	....	....	....
1	....	1	1	....	1	....
....	....	....	....	....	....	....
....	....	....	....	....	....	....
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STAFF NURSES

104	37	67	90	52	38	38
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....	....	....	....	....	....	....
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....	....	....	....	....	....	....
3	....	3	6	6	....	7
1	....	1	2	....	2	1
1	....	1	....	....	....	7
3	....	3	6	5	1	6
18	1	17	9	8	1	4
26	8	18	34	15	19	7
5	3	2	11	10	1	1
19	9	10	4	2	2	2
14	8	6	6	....	6	3
7	6	1	1	1*	....	....
1	....	1	4	1*	3**	....
2	2	....	....	....	....	....
....	....	....	....	....	....	....
4*	....	4*	3*	3*	....	....
....	....	....	3*	....	3*	....
....	....	....	1*	1*	....	....
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RED CROSS PUBLIC HEALTH NURSING

EDITED BY ELIZABETH G. FOX

DAY BY DAY

EDITOR'S NOTE: Each month the Red Cross Public Health Nurse submits with her statistical report a narrative which gives color and life to the record of her work. These bits, which are excerpted from the narratives of nurses serving in rural Red Cross chapters within the Central Division territory, give only a glimpse of the variety and interest found in the everyday work of the rural nurse.

A MOTHER who attended the classes in Home Hygiene last summer kept her son isolated at home because he had a slight sore throat. When she saw my car in the school yard she brought him to me, saying she wished to take no chances of infecting other children—should he go to school or see a doctor?

* * * *

Whenever I plan to visit a school the teachers send personal invitations to the parents to come at the same time. Some of the parents bring younger children to be inspected and recently one mother brought an eight weeks old baby to ask why it didn't grow. In one school two of the fathers left their farm work to be present. But best of all the children do not stay home to avoid inspection. In some cases when they are obliged by work to remain at home they will come just for my visit, as did one boy who was plowing. When he saw me he tied his team, came on to school for his inspection and then went whistling back to work.

* * * *

So far this fall, I haven't found many corrections, but the mothers are attending inspections 100 per cent and they bring all the pre-school children. This, I am sure, will mean corrections next year. The "getting together" stimulates interest. Parent-teacher units have been organized in all schools except one.

* * * *

Vacation month—and it is hard to keep out of work. One ought to get out of town right away, especially if there is no one to take one's place. One of my people said, "What are we going to do without you?" I replied, "Just what you did before I came."—"Oh, that is easy to say," was her answer, "But it is the same with you as with an auto, when once we have you, we can't get along without you."—I began school work this fall by looking over the girls from the fifth to twelfth grades scheduled for gymnasium work. As a result of this inspection, 55 were asked to see their doctor before taking up work. All have not reported back, but quite a number because of their physician's recommendations have been excused for the fall term or for the entire year, some will rest during the gym period, others will take only light work. Such recommendations prove that inspection is quite worth while. . . .

I have also done a bit of Americanization work this month. I went to the home of a Greek woman to show her how to cut and sew together dresses for her little girls who have entered school this fall for the first time. Also I have shown her how to can fruit and pickles and taught her many other home-keeping helps. She was most appreciative. Though she spoke no English, I knew by the way she kissed my hands that she was doing all she could to show her thanks and pleasure.

* * * *

A few days ago the nurse employed by the Tuberculosis Society of La Salle wrote me about a girl, excluded from the La Salle schools because of active tuberculosis, who had come to our town to live with a married sister. I had neither the correct name nor address for the sister so I asked every mail-carrier I met until finally the girl was found. And she was in school!

The first week of this month was

given over to the County Fair. For the past three years the Chapter has conducted a rest-room in a building ideal for the purpose. Originally it was an eating house. The large room is divided by a woven wire fence to make three sections. The largest section is the children's playroom. It is furnished with sand pile, tables, chairs, toys and a victrola. One section contains a cot and an assortment of chairs where people may rest, the third section, equipped as an emergency room by the local hospital and managed by one of the student nurses, can care for all cases except those requiring operations. Adjoining the big room is a shed room which we use as a nursery. Here we check babies and the service has proved so satisfactory that the Fair Association say it is a drawing card that cannot be dispensed with. This year one of us has given her entire time to the nursery and it has been most satisfactory for there has been time to talk to the mothers about diets and sleep and clothing with good results.

* * * *

The interesting thing that stands out this month in the school work is the number of corrections which were made immediately after the home calls. Two tonsillectomies, one dental correction, and an application for orthepedic care are the record in one district with only six families. All the credit goes to the teacher whose interest in the children was a stimulant to me.

* * * *

As I visit the schools I take the Junior Red Cross Christmas boxes. If the school wishes, one is left for filling. The children's response is gratifying. I also carry to each school, for its library, a packet made up of government pamphlets on health and one of the good posters made by another school last year. It is my hope that these things will help in the making of better posters this year. I have also arranged for the Public Library a table of books and magazines dealing with various phases of health and ill health. There is a large sign above it so that the teachers and others will have little trouble in finding references.

* * * *

We have had ten baby conferences in the rural districts this month with an attendance of ninety-seven babies. Seventy-one were examined by the doctors. About ten of the others were examined by a doctor on a previous visit. Since June 12th, when we held our first Infant Welfare Conference, we have had 250 babies—or rather preschool children, out. I have made home calls on quite a number of my underweight babies. One who was three and one-half pounds underweight last month was only one and one-half underweight this month. Two whom the physicians thought might be tuberculous have each gained over two pounds. This work certainly seems worth while.

* * * *

Our chapter has been interested in a family that was stricken with malaria en route to Colorado. The family had camped at the town's tourist park. . . . I found their truck parked under the hedge, the father very ill and several of the children not well. They had no food and needed shelter badly. Those who slept in the "lean-to" of canvas were wet from river mist each morning. . . . Houses are very scarce in our town but our perseverance won. Three weeks ago the family had a home. One of the chapter officials donated two cots from his store for the sickest members. The others have mattresses on the floor. Everyone in the family has been ill, but now most of them are well enough to be up and about. They have been helped along in various ways, and nursing care was no small part. . . . Now it is interesting to watch their efforts to help themselves. Basket makers by trade, they have sold their small victrola to buy a supply of straw and are making beautiful baskets which find a ready sale. These sales, so the family say, will soon be sufficient to pay expenses until the father is equal to other work. It has been pleasant to help a family "out of luck" and away from friends.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING SERVICES

DISCUSSIONS OF SUBJECTS BEGUN IN PREVIOUS NUMBERS

PHYSICAL EXAMINATIONS FOR NURSES

The plan which we hope to put into effect January 1 is as follows: Each nurse will be asked to pay for a complete physical examination and to file the record of this examination with the Visiting Nurse Society before the end of the three months' probation. After that the organization will pay for one examination a year for all staff nurses. The details for this have not yet been worked out but with the recommendations made at the National Convention, I do not believe there will be any difficulty in the matter.—*Instructive Visiting Nurse Society, Washington, D. C.*

Through the efforts of a special committee of the Board of Managers a list was prepared of fifteen doctors willing to serve the Organization by giving annual health examinations to the staff free of charge.

Such an examination is required for each nurse admitted to the staff and yearly thereafter. The list of doctors is posted, and a nurse may choose from the list the doctor she prefers. Specialists are included in this list.

The arrangement was made in 1920 after consultation with the staff.—*District Nursing Association, Providence, R. I.*

The Visiting Nurse Association of Detroit has always required applicants to present a health certificate from a physician before receiving an appointment to the staff. For a number of years there has been an arrangement with the Health Department which gave the Visiting Nurses the privilege of a physical examination by the Health Department physician. Until 1923 this examination was optional but since that time it has been required.

The Health Department has not only continued its generosity but has increased it, as our entire staff of seventy-six nurses has the privilege of an annual examination there and access as well to the nurses' physician's daily "sick call" hour. The latter service has been offered as a preventive measure to check the minor ills before the nurse is too ill to remain on duty. About two-thirds of our staff avail themselves of the physical examination at the Health Department but very few use the "sick call" privilege, chiefly because of the time element, as none of our centers are near the Health Department.

The nurse may choose her own physician and about one-third prefer to do this, in which case we require that the results of the examination be recorded on a form furnished the Association. At present, in order to clear our files, we try to have all the examinations made in February and March. We are of the opinion that the most advantageous time to have the nurse examined is after three months in the service. Thus, those who are not physically able to do visiting nurse work would be detected early and much "turnover" and extended sick leave might be avoided. We intend to seek the advice of our Medical Committee on this point before changing our present routine.—*Visiting Nurse Association, Detroit, Michigan.*

For the past three years we have required a health certificate from a physician upon the admission of each new nurse on our staff. The physical examination is generally made by the nurse's own physician. If the nurse is a stranger in town we send her to one of the physicians with whom we are associated. We have felt that the statement presented by the nurse has not always been satisfactory, due no doubt to the fact that she does not understand that we want a thorough physical examination.

We always feel at liberty to send a nurse to one of the physicians on our Medical Advisory Committee, whenever a special examination is necessary.

We have never arranged for yearly examinations for the entire staff although I feel it might be wise for us to do so. However, for our nurses doing tuberculosis work we have, for the last year, had examinations every three months, such examinations being made by the physician in the tuberculosis clinic. The nurses do not feel that they are in any way compelled to have these examinations, but are glad to have them.—*Visiting Nurse Association, Kansas City, Missouri.*

Regarding physical examinations, the Civil Service Commission requires a physical examination for all candidates taking the examination. We felt this had not been as thorough as we would like, so the Nursing Commission wrote the following letter to the Civil Service Commission:

> The Nursing Commission would recommend that all candidates for positions on the nursing staff of the Los Angeles Health Department be required to undergo a physical examination before coming up for the regular civil service examination.
>
> This examination should cover the heart, lungs, abdomen, with special reference to the appendix and gall bladder, the eyesight, hearing, and feet, also urine analysis and a general examination as to nourishment and anaemia. The menstrual history of the candidate, with special reference to the amount of disability suffered at this time, should be gone into.
>
> We feel that such an examination will materially help the department in weeding out candidates who might be thoroughly competent in a professional way but whose physical condition is such as to render her inefficient for the work required.

They complied with the request, and the results have been very satisfactory. We have no plan, at present, for a reëxamination, but we are hoping to work out some plan whereby each member of the staff can be required to have a complete physical examination once a year.

Bureau of Municipal Nursing, Los Angeles, California

TRANSPORTATION

We reprint the questions which appeared in December.

1. *What is the best make and type of car for nurses' use?*
2. *What is the cost of operation and upkeep?*
3. *Who should be responsible for the car? Does a committee check up on costs?*
4. *If a nurse uses her own car what financial adjustment is made?*
5. *Should nurses use association cars in off duty time? On what terms?*
6. *How do nurses learn to run cars? Who pays for lessons? Is this done on association time?*
7. *Cost of automobile transportation compared with value of actual time saved? Can a nurse double the amount of work if car is provided?*
8. *Experience of Volunteer Motor Corps.*

The Bureau of Municipal Nursing, Department of Health, Los Angeles, a brief statement of whose earlier transportation policy was printed in this department in December, has now furnished us with more detailed information in direct reply to the questions.

1. Our experience proves that the Ford car is the most satisfactory because of the lower operation cost. It is also much easier to secure help for minor repairs, if a nurse should need this when some distance from a garage, as almost every man understands something about a Ford.

2. Can give no actual figures of the cost of operation and upkeep, as we have a municipal garage, where repairs for all city cars are taken care of.

3. A nurse driving a city car is held responsible for seeing that it is kept in good condition by the municipal garage.

4. Six cents per mile.

5. There is a ruling that no city employee is permitted to use a city car excepting for city business.

6. When we received our first cars nurses were taught to drive on city time by another nurse who was an experienced driver, but since our staff has increased and we have so many cars, also the majority of new nurses taken on to the staff own cars of their own, we no longer do this.

7. Our records show that since the nurses have been using cars our travel time for the entire staff has been reduced from 22.2 to 17.2 in our time distribution. In a congested district we do not consider it advisable to have a nurse use a car as she can make as many visits in a day as we feel is desirable. It is our policy to increase the number of cars in proportion to the increase of our staff.

8. We have had no experience with volunteer motor corps.—*Los Angeles.*

This is the transportation plan of the Alabama State Board of Health: A new Ford coupe costs $611; with a slight advance on this price they may be paid for on the instalment plan. An allowance of $16.67 per month for depreciation amounts to $200 a year, in two years this replaces $400 of the purchase price. When a Ford has been used for two years it is too expensive to pay maintenance cost on and we recommend that it be

turned in on a new car. If it has been well taken care of it will usually bring in exchange practically the entire difference between $400 and $611, so that the ownership of the car has not cost the employee much if anything. The expense of running the car, gas, oil, tires, engine repairs, etc., are borne by the state, receipts are taken for all of these items and filed with vouchers for which a check is given. The only running expenses which would not be refunded would be those for repairs to improve the appearance of the car, such as painting.—*Bureau of Child Hygiene and Public Health Nursing, State Board of Health, Alabama.*

Pittsburgh has but one cross-town trolley line, that going from the center of the shopping district to the north side (old Allegheny City). The result is that one is obliged to ride to the center of the city in order to get north or south from a given point east of the center of the city.

Of the ten substations being operated by this organization, only one requires its staff nurses to report in the morning. The remainder have each nurse go to her own district, reaching the first patient's house at 8:30 A.M.

Transportation via trolley—8 1/3c fare—is furnished when on duty in addition to two car checks daily, paying for transportation to and from her home. In instances where the nurse is obliged to use two car checks each day, she herself is responsible for the second one.*

One automobile—Ford touring car—is owned by the organization and used exclusively by the Child Welfare Division. One nurse has an automobile of her own, the garage rent for which is paid by the organization. A few nurses have Fords which they use at their own convenience. No plans have been made for the upkeep of these by the organization.

The topography of Pittsburgh is extremely difficult. The streets are narrow for the most part, with hills almost insurmountable in many places, making it necessary to go around rather than over them.

The big problem of our transportation lies in the fact that the car lines in many instances stop—and this within the city limits—at least ten blocks from a patient's house, which frequently means a walk of from ten minutes to three-quarters of an hour from the end of the line.—*The Public Health Nursing Association. Pittsburgh. Pa.*

* The Pittsburgh Association asks this question:
What are other organizations doing when the nurse lives where either two car checks or a railroad fare is necessary?

RESPONSIBILITIES OF THE NURSE IN SOME POINTS OF BABY WELFARE WORK

In the January number it was announced that the following questions would be diecussed in this department. We have received replies from four cities and hope other organizations will add to the discussion later.

Question 1. Is it permissible for a nurse in the field to raise, lower or otherwise change the formula of a baby under her supervision?

Those who have so far responded to the request for contributions to this discussion are agreed that the nurse should not change the formula of a baby except by the standing or specific order of the conference physician or the private physician and any change so made should be reported to him.

Question 2. How much responsibility can the nurse assume for a baby whose mother does not bring it to the conference and does not have a family physician?

The nurse can assume the responsibility of patiently, tactfully, cheerfully, tirelessly attempting to create in such a mother a real desire to place the baby under proper medical supervision and all the while the nurse should give such direction and instruction as is included in general infant care. If proper medical supervision is not available as in isolated communities, the nurse may put the mother in touch with the proper literature for her guidance.—*University Public Health Nursing District, Cleveland.*

If the nurse has been trained in infant welfare and if the home conditions are such that the mother is unable to consult a physician or attend the well baby conference, there is less harm done to the baby if the nurse prescribes the formula than there is if the mother follows her own ideas which so often run to condensed milk. This is the exception, however, and the nurse should use every means to get the baby in to conference as soon as possible, and consult with the conference physician frequently in the meantime.

If the mother is able to attend conference but is negligent and lazy, the nurse should not assume the responsibility which rightfully belongs to the mother of obtaining the necessary advice for feeding her baby.—*Public Health Nursing Association, Pittsburgh.*

Our policy would be not to carry the case if there is no physician to guide the feeding of the child.—*Public Health Nursing Association, Rochester, New York.*

A nurse assumes no responsibility beyond giving advice regarding general hygiene.—*Community Health Association, Boston, Mass.*

Question 8. How long should a baby be carried under these circumstances?

We feel that it depends on the individual cases. If the baby is a breast-fed baby, gaining normally, we would carry it three or four months. If the baby is not gaining and needs medical supervision we would carry it for no longer than three weeks and then tell the mother that when she has directions from a physician we shall be glad to help her with them.—*Public Health Nursing Association, Rochester, N. Y.*

The nurse carries the baby who has registered at conference for three months. If the mother does not return to conference within that time, the case is discharged. Sickness, bad weather, great distance from the conference rooms, and like causes are considered ground for exception to these rules.—*Community Health Association, Boston.*

This question is one, I believe, which has to be considered for each individual case. If the nurse is convinced that the mother is unable to obtain medical advice, either from a private physician or by attending conference, I think she should carry the baby indefinitely, but always consulting with the conference physician at frequent intervals. If the mother is not interested and the nurse has not been able to interest her after four months, I think the case should be closed, and the time given to mothers who will coöperate and are interested.—*Public Health Nursing Association, Pittsburgh.*

Why should we ever cease to care for a baby just because the mother does not respond as we desire? Does not such a babe need such a never-failing friend as the public health nurse? Such a situation is, to my mind, a fascinating challenge to the alert and capable nurse.—*University Public Health Nursing District, Cleveland.*

V.N.A. STUDY REPORT

We will publish in the March number some of the questions which have been raised in relation to the Report of the Committee to Study Visiting Nursing, and the answers to these questions which have been agreed upon by the Visiting Nurse Study Advisory Committee.

SPEAKING OF TRANSPORTATION

When anyone is found unconscious on the floor of a garage with the engine of the car running it is pretty safe to fear carbon monoxide. The first act is to open wide the doors and shut off the engine. Sometimes the engine shuts off automatically because even it cannot run without fresh air. The rescuer should hold his breath and drag the victim out into the air. Medical help should be summoned at once. An ambulence is not the thing needed, but an expert in resuscitation. If life is to be saved it must be saved then and there without waiting to remove the victim any distance. Suffocation by gas requires the same treatment as suffocation by smoke or by electric shock or by drowning. A person who has learned to treat victims of any of these causes of suffocation will be helpful in treating persons suffering from any of the others. Every policeman and every fireman should be carefully trained in treatment for suffocation. It is purely mechanical treatment—applying and releasing pressure over the floating ribs of the patient, who is lying face downward on a flat surface, the arms higher than the shoulder level.

—*Red Cross Courier, January, 1926.*

REVIEWS AND BOOK NOTES

THE NEW HYGIENE

By H. W. Hill, M.D.

The Macmillan Co. Price, $2.50.

In his book "The New Hygiene," Dr. H. W. Hill accomplishes his avowed purpose of attempting to give to students of hygiene such an understanding of their own bodies that they may know something of the art of living their own lives well, with comfort and efficiency. This is accomplished first of all by explaining the "new" hygiene. Many and varied have been the interpretations of the terms hygiene and sanitation, and this author by means of clever comparisons and unusually clear cut definitions, gives the student a true conception of these terms.

The chapters dealing with nutrition and nutritional hygiene are of great value to any reader. The facts are presented in such a manner that the reader understands the reasons why nutrition is such an important factor in hygiene. The tables presented are of practical value.

The book itself attracts the eye of the student and the plan of summaries of chapters and projects for groups of chapters are not only happy surprises but help to crystallize the thought and inspire further study and research in very practical problems.

Last but not least, is an appendix of some fifty pages entitled "A Short Course in Modern Public Health" which should be read and put into practice by everyone. It is written in an optimistic, forceful style, using italics, facts and striking figures to arouse the reader to things as they are; to the accomplishments of the past and to the challenge of the present and the very near future when disease can be abolished. The reader is assured this is no idle dream and feels a new urge to secure the promotion of health, through the practice of Dr. Hill's three simple rules, "The first great rule being, moderation in all things," the second, alternation of activity with rest at frequent intervals, the third, and this applies mentally and morally, as well as physically, "Keep Cool!" What might be the result if the thousands of public health nurses in the United States practiced conscientiously these three simple rules, one can not venture to say!

Dr. Hill, through his clear thinking, careful analysis of facts, clever figures, accurate and forceful statements, has given the public an invaluable service in this masterly presentation of an important subject.

MARION G. HOWELL.

L'INFIRMIERE

By Mme. Edouard Krebs-Japy

Librairie Armand Cohn, Paris, France

"L'Infirmiere" is the first book published in France giving the list of schools for would-be nurses, is from the pen of Mme. Edouard Krebs-Japy, whose thesis on Hospital Social Service was reviewed in the December, 1923, number of this magazine.

A medical student in Paris Hospitals, she has written of extended experience in Paris hospital Institutions. But one wonders at her broad comprehension and appreciation of the best in English and American nursing methods and progress. The Bibliography presented shows important sources of inspiration. Certain it is that her outlook has been affected by the high ideals and uncompromising standards of Dr. Anna Hamilton of Bordeaux. Her quotation from Dr. Hamilton in the Introduction shows the purpose of the book:

"Tell everything that can enlighten possible candidates, all that can attract young women to the most intelligent, the best qualified, as to moral worth, so that for the future of France, this greatest career open to women may be elevated to adequately high standards."

The important place of the nurse in society, the strong appeal the service holds for women desiring to be useful, and the necessity of thorough training for such a career,—Mme. Krebs-Japy

gives in the discussion of these to the young women of France desiring to realize the ideal for which their brothers have died, food for serious thought and important decision.

Lists of the Schools for Nurses in France, and of Special Courses in Nursing and allied activities are given.

Under all the headings the number of so-called schools and courses is surprisingly large. But we must recall that many are listed that would by no means measure up to every minimum standard. For each school are given conditions of admission, somewhat as to course of study in theory and in practice, living conditions, etc.—in brief such facts as a prospective candidate for admission would want to know. Presumably in this book a comparison of the various schools, is held to be out of order. But to measure them all according to the high standards Mme. Krebs-Japy herself sets forth as so necessary, that would indeed be a courageous but a most helpful service to the French public.

Still further to inform and inspire, the various branches of service open to the graduate nurse are presented as from an understanding heart, and high tribute is paid the Public Health Nurse, and the Nurse in Hospital Social Service, as representing " two paths rich in their immense perspective."

The last words in the book reiterate the author's praiseworthy purpose " to help in elevating nursing in France to a level worthy of our country from its illustrious past and its moral situation in the world today."

HELEN SCOTT HAY.

CONSTRUCTIVE CONSCIOUS CONTROL OF THE INDIVIDUAL

F. Matthias Alexander.

E. P. Dutton & Co., New York, 1923, $3.00

For those who are merely seeking some quick alleviation for their own woes, Mr. F. M. Alexander's book " Constructive Conscious Control " may doubtless be dismissed with a superficial criticism, but those people who are looking for some underlying reason why the world with all its boasted civilization is in chaos, why our children, even at the age of two and three, are beginning to develop wrong habits in the use of themselves, may well adopt the method of one Englishman who decided to leave all other books behind on his six weeks vacation so as to give all his reading time to " Constructive Conscious Control."

Mr. Alexander not only gives us reasons for our present condition, but he also points the way out.

He shows how man through all generations has been largely guided by his feelings, his instincts, and whereas these feelings in earlier days were generally reliable, with the constnt environmental changes of the last centuries and particularly the last 50 years these feelings are no longer to be trusted, and to-day each individual is guiding himself in his every-day acts and thoughts by a control, to a large extent a subconscious one, based on unreliable sensory impressions. He believes that these feelings begin to " go wrong " at a very early age. He endeavors to prove this by many simple examples.

He speaks of the futility of dealing with the human being as if it were made up of separate entities, the mind, the soul, the body, and believes that it is an entity which must always be regarded as a coördinated whole. Up to this time, although these facts may have been conceded, no method has been devised whereby a human being can be treated as a whole so that he can know how to manage him or herself as a coördinated being.

He offers a remedy by giving through his teachings a means whereby human beings may be taught to be masters of themselves, a method which is based on fundamental scientific principles.

This remedy, which has produced remarkable results in adults, interests Mr. Alexander mainly in its potentiality in regard to preventive work with children.

All of us who are striving to understand why the many forms of physical

exercises given to our children are failing to make them fine coördinated beings may well apply the law of inhibition which Mr. Alexander makes use of and stop long enough to read his book and to make up our minds whether Prof. John Dewey is right when he states his belief in the Introduction to the book, that Mr. Alexander "has demonstrated a new scientific principle with respect to the control of human behavior as important as any principle which has ever been discovered in the domain of external nature . . ." ". . . a discovery which makes whole all scientific discoveries and renders them available not for our undoing, but for human use in promoting our constant growth and happiness."

KATHARINE B. CODMAN.

U. S. Public Health Reports, Vol. 39, No. 30, December, 1924, contains *A Survey of Public Health Nursing in the State Departments of Health*, compiled by Lucy Minnigerode, Superintendent of Nurses, U. S. Public Health Service.

This presents valuable and definite information, hitherto uncollected, on the pertinent facts relating to public health nursing in 44 States, Alaska, the Philippine Islands, Hawaii and the District of Columbia.

Under the head of Organization and Administration is included information on the following points:

1. Division or bureau of public health nursing as a separate unit in the department of health.
2. Supervision of this unit with title of both bureau and supervsor.
3. Organization of the nursing service and coördination of activities of health department with voluntary public health nursing organizations for the prevention of wasted effort and duplication of work.
4. Medical supervision of nurses.
5. Number employed, with salary range.
6. Percentage cost of nursing to total health budget.
7. Extent of work.

This has been summarized and tabulated into three tables,

Organization.
Salary Schedule.
Summary of Duties of Nurses.

A fourth table summarizes State Supervision of Voluntary Nursing Agencies.

The general information obtained by the survey is summarized by States. In reply to the question as to "The Value of Public Health Nursing as an aid to the State Health Department," Connecticut goes on record:

Public Health Nursing *is* considered an aid to the State Health Department. It would take a manuscript to answer such a question as this.

While Arkansas reports:

Next to an efficient director, an efficient public health nurse is the most important part of any public health unit.

We are glad to say that most of the states speak with some enthusiasm on this question.

Write for a copy to Superintendent of Documents, Government Printing Office, Washington, D. C., price 5 cents.

Handbook for Queen's Nurses, by Some Queen's Superintendents, Scientific Press, London, England, 1/6.

This small volume, with an introduction by Miss A. M. Peterkin, General Superintendent, Queen Victoria's Jubilee Institute for Nurses, gives, as its title denotes, general information "out of the experience of many years," compactly arranged for that fine group of Englishwomen known admiringly and affectionately as "Queen's Nurses." We are struck by the note of humanity all through the little book,

First and foremost, the thought of the nurse must be for her patient. . . . Should he not see the need of all she knows to be necessary for his comfort and recovery, she must go to work very tactfully, carrying out her duties with kindness and common sense. She should give every consideration to his wishes, yet so manage that nothing essential or helpful to him is left undone: indeed the patient's approval of her procedure should be won.

And again,

The ideal nurse for district work must, in addition to full hospital and district training, possess the qualities of tact, patience, discretion, adaptability, and common sense, with sound health and a real love of humanity. She must always be willing to learn from the experience of others. . . . She must be equal to speaking, as occasion arises, with clearness and

wisdom on the principles of right living and a better standard of life. Her manner should be gracious and her judgment sound.

Our old friend, *The Child Health Magazine*, will, after the January number, greet us no more.

The American Child Health Association has decided to replace the magazine by a bulletin published from time to time containing information on special subjects. Other material which it desires to bring before the public will be distributed through the medium of other magazines. The bibliography which has been a valuable feature of the magazine will, however, be published regularly.

We bid the magazine a regretful farewell, with memories of the sum of useful knowledge it has contributed to us in the past.

We wish *The Red Cross Courier* in the new form a happy and successful New Year. Not having informed ourselves of the prospective change the 1925 model came as a distinct but agreeable shock with its excellent illustrations and its diversified text. Also we approve highly of the fact that it will now appear semi-monthly.

The Journal of Social Hygiene, January, 1925, publishes *A Review and Forecast of Social Hygiene* by Sybil Neville Rolfe, General Secretary, National Council for Combating Venereal Diseases, London, England, which presents this complex subject from an international point of view with such clarity and distinction that we wish for all nurses an opportunity to read the paper.

We present a statement submitted by Mrs. Rolfe to the Board of Directors of the American Social Hygiene Association to further the movement of English speaking groups throughout the world to arrive at common grounds in outlining their programs. The statement was approved in principle and referred to the executive committee with power.

It is recognized that social hygiene in its widest sense includes all things that have to do with the welfare of human beings living in societies; but for the purpose of this organization, it is proposed to devote attention to the following points by disseminating the knowledge acquired in the medical, psychological, sociological, anthropological, and other fields of science in order to form an instructed public opinion and to secure action when possible.

1. To preserve and strengthen the family as the basic social unit.
2. To promote educative and social measures toward the adaptation of the racial instinct to the conditions of civilized society.
3. To emphasize the responsibility of the community and the individual for preserving or improving the quality of future generations by educative and social measures.
4. To further social customs which promote a high single standard of sex conduct in men and women.
5. To promote the prevention and treatment of venereal diseases by appropriate educative, medical, and social measures.
6. To repress commercialized vice and conditions conducing to promiscuity.
7. To coöperate with the various organizations interested in the above subjects with a view to coördinating efforts to secure these ends.

The Mississippi State Board of Health has prepared a large, imposing, and admirably arranged presentation of its health services in the form of a four page Calendar for 1925 which, hung on the wall of the Mississippian's home, ought to give widespread knowledge of the accomplishments and needs of the Board of Health. It is embellished with admirable charts, maps and other illustrations, which together with the excellent text, should provide plenty of food for thought to that elusive individual "the man on the street."

The Quarterly Bulletin of the New York State Department of Health prints an article by Dr. L. T. Genung on *The Control of Diphtheria*. Dr. Genung summarizes his conclusions as follows:

1. There are at present few diseases about which we know as much as diphtheria.
2. The discoveries of Klebs, Loeffler, von Behring, Schick and others have given us the means for its complete control and eradication.
3. The reason for the continued high morbidity and mortality rates lies not only in the widespread ignorance of the general public as to the effectiveness of these control measures, but also in the general indif-

ference of many members of the medical profession in urging their adoption.

4. The chief hope for the future control of the disease seems to lie in the active immunization of the child population by the use of toxin-antitoxin, but this to be most effective must be done in early childhood—preferably between the ages of six months and two years.

The Nation's Health, December, 1924, publishes an article on *A Health Officer's Idea of a Public Health Nurse* by Dr. John A. Sippy, Stockton, California. The subtitle to this interesting paper—which shows a sympathetic familiarity with the human as well as the professional side of a public health nurse's life—is: "She Is Not a Superwomen and She Daren't Be a 'Dumbbell.' She Mustn't Prescribe and She Mustn't Diagnose; But Her Opinions Are to Be Respected."

We quote the concluding remarks:

In all finality, what shall the health officer expect of the public health nurse?

First, that she be answerable to him for her employment.

Second, that she carry out his instructions implicitly and obediently, he always having a due regard for her opinions and advice.

Third, that she does not usurp authority or duties which legally are vested only in him and not in any voluntary organization or nonofficial physician employed by any other agency.

The following verses published in *The Literary Digest* shows a perhaps natural revolt against "health habits":

I wish I was a gold fish
Who hasn't any mind—
I'd grin from gill to gill before
And wag my tail behind.

I wouldn't have a nose at all
So wouldn't have to blow it,
And if I blushed nobody'd know
Because I wouldn't show it.

I wouldn't have to comb my hair
Nor clean my teeth or nails,
The only job I'd have to do
Is finicure my tails.

Seeing is Believing is the title of a recent pamphlet issued by the American Child Health Association, 370 Seventh Avenue, New York, N. Y. The sub-title is How to Visualize Health Through Posters and Other Projects. Reprints of articles recently published in the *Child Health Magazine* make up this pamphlet, which will be of special interest to school nurses. Well illustrated. Price ten cents. We quote:

A Ten Point Rule for the Poster

1. Its design must be concrete and definite.
2. Its wording must be terse and accurate.
3. It must express vitality; even "still life" need not be dully passive.
4. It must be stimulating.
   It must arouse thought.
   It must give pleasure; originality, imagination and humor are its assets.
   Its appeal must be instinctive.
5. Its arrangement must be directed to a central focus of interest.
6. Its lettering must be, first, legible, and then artistic.
7. Its color scheme must be simple but bold.
8. It must be unerringly neat.
9. Its shape must not distract the attention.
10. Its size must be fitting for its intended place and purpose.

The new pamphlet called "Milk," published by the American Child Health Association, replaces in their material the little article called "Milk, the Master Carpenter," which was contained in "Health Plays for School Children" now out of print. A new collection of plays will soon replace this book. "Milk" is an attractive eight-page folder, containing a description of the ingredients, uses, value and scientific conclusions reached concerning this "perfect food," and will be interesting to lay people as well as to public health nurses. It can be used in health centers and clinic waiting rooms and in instructive home visiting. Price, six cents a copy. 370 Seventh Avenue, New York City.

The Children's Bureau, U. S. Department of Labor, has recently issued Bureau Folder No. 3, *"Why Drink Milk,"* which gives in popular form the reasons why milk is an indispensable food for children. Distributed free.

The price of the revised *List of Health Films,* prepared by the National Health Council, 370 Seventh Avenue, containing data on over three hundred motion pictures, has been reduced to 20 cents.

NEWS NOTES

One year ago a Joint Executive Board was organized to coördinate and standardize the public health nursing and clinic work of the Visiting Nurses and Babies Milk Fund Association of Evansville, Indiana. The Board consists of ten members selected from the two associations, each sharing equally in the membership.

Last August Miss Hulda A. B. Cron was made superintendent for both associations. Up to the 31st of December, 1924, these two organizations occupied separate offices in different sections of the city. Through the excellent work and coöperation of the members of the associations and the Joint Executive Board, the two nursing organizations now occupy a joint office and to all outward appearances function as one unit. The salaries of the stenographer and the clerk are divided equally.

The new quarters are now known as the "health center," the names of the two participating agencies being subordinated. They are unusually attractive and quite superior to the average health center quarters one usually finds in a city of 100,000. The county officials redecorated the entire suite, which is in a modern and centrally located building.

A special point of interest is the new definition and scope of public health nursing activities of the two associations which became effective January 1, 1925. Up to this time, both associations were doing prenatal and maternal nursing, while the Visiting Nurses Association also cared for children of preschool age. The newly adopted policy provides that the Visiting Nurses Association shall care for all patients above six years of age, which, of course, includes the prenatal and maternity services. As the maternity cases are closed, the Visiting Nurses Association staff refers the babies to the Babies Milk Fund Association staff for prophylactic care. The Babies Milk Fund Association staff do all the nursing work for children up to the age of six years.

Dr. A. R. Warner, Executive Secretary of the American Hospital Association, died November 27. Dr. Warner's first hospital position was Assistant Superintendent of Lakeside Hospital, Cleveland, Ohio. In 1913 he became its Superintendent, a position he held until his appointment as Executive Secretary of the American Hospital Association in 1919.

From the beginning of his hospital career he was actively interested in the work of the Association, serving on several of its important committees. In 1918 he was elected its President. His earnestness and enthusiasm in the organization of hospital activities won for him not only nation-wide, but international, recognition.

Miss Mary E. Murphy, who for some years has held executive positions with the Elizabeth McCormick Memorial Fund, has been appointed its director. Miss Murphy, while assistant director, was associated with Mrs. Ira Couch Wood, late director of the Fund.

Nutrition work, general health education and educational research now form the main objectives of the Fund, which in its early years was largely concerned with work for infant welfare. Later it established and coöperated in maintaining the open air schools in Chicago, and promoted the standards elsewhere.

Miss Evelyn T. Walker, Directrice de l'Association d'Hygiene Sociale de l'Aisne, upon whom the French government recently bestowed the Cross of the Legion of Honor, has been presented with a bronze statue inscribed with the name of each member of the Syndicat Medicale de l'Aisne. The statue, a beautiful bronze by the eminent sculptor M. Levasseur, represents a woman, her foot on a sword, her face set toward a longed for goal. The inscription reads:

Vers la Paix
a Miss Walker
Les Medecins de Soissons et des
Environs
Reconnaissants

A change in both name and location of The Friends of Medical Progress became effective recently when this national organization, formed to disseminate medical knowledge among the general public, changed its name to the American Association for Medical Progress and took up its residence at "370" Seventh Avenue, thus becoming a neighbor of the N.O.P.H.N. Benjamin C. Gruenberg, well known to workers in the field of education and public health, will be in active charge of the organization, which has as honorary president Dr. Charles W. Eliot.

We correct an error in the January number. The officially appointed secretary of the Child Welfare Section has not yet been appointed. Miss Dorothy Rood, whose signature appeared on the report of the Section, was secretary *pro tem.*

STATE MEETINGS

Iowa

The 21st Annual Meeting of the Iowa State Association of Registered Nurses held in Des Moines, November 18–19–20, 1924, was considered by all to be the best state meeting they had ever attended. The plan adopted two or three years ago for the meetings was carried out in arranging the various general programs; namely, devoting one whole program to each of the three departments—League of Nursing Education, Public Health Nurses, and Private Duty Nurses, one outstanding speaker being secured for each.

Dr. L. D. Moorhead, Dean of Medical School, Loyola University, Chicago, and Miss Bena Henderson, Superintendent, Children's Hospital, Milwaukee, spoke on subjects relative to schools of nursing. Major Julia Stimson was the outstanding speaker in the Public Health Section and Mary Gladwin, R.N., LL.D., St. Paul, on Private Duty.

Other speakers and their subjects included: Psychology of Ethics, Dr. S. C. Sonnichsen, Des Moines; Insurance as an Investment, Dr. Frank Warren, Des

Moines; Summary of Recent Experimental Work in Scarlet Fever with Demonstration of the Dick Test, Dr. Lee Hill, Des Moines; illustrated lecture on Normal Growth of the Child, Dr. Bird T. Baldwin, Iowa City; The Nurse and Neuro-Psychiatric Problems, Dr. Frank A. Ely, Des Moines; Teaching Health to the Public, Mr. John P. Ryan, Grinnell; an Address and Cardiac Clinic, Dr. Merrill Myers, Des Moines.

Because the program was so heavy, special efforts were made to introduce entertainment and variety in the program. A pageant on the History of Nursing was very well received.

The banquet on the second evening was an especially lively one. There was no program but each district responded to roll call with a stunt. Following that, each Des Moines School for Nursing presented a musical or dancing number. The last feature was a "ceremony of the cake," celebrating the 21st Annual Meeting of the Iowa State Association. One of the nurses dressed as Father Time related the history of the Association from its birth to its 21st birthday.

Following the banquet was a theatre party, the proceeds of which were applied to the Nurses Relief Fund. A number of local groups gave specialty numbers between the acts. Des Moines student nurses occupied the gallery and gave school yells and songs.

The meeting closed with an automobile ride about the city and tea at Broadlawns, the new Polk County Tuberculosis Sanatorium.

The officers of the previous year were re-elected with the exception of the treasurer, Miss Margaret Henke of Keokuk being elected to take the place of Miss Veronica Stapleton who has gone to the James Whitcomb Riley Children's Hospital in Indiana. The Association voted unanimously to hold the next annual meeting in Davenport.

Maine

The Maine State Nurses' Association held its annual meeting in Portland, January 8–9, with about 80 in attendance.